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Development of an Instrument to Identify the Virtues of Expert Nursing Practice: 'Byrd's Nurses Ethical Sensitivity Test' (Byrd's Nest)

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The University of Southern Mississippi

DEVELOPMENT OF AN INSTRUMENT TO IDENTIFY THE VIRTUES OF

EXPERT NURSING PRACTICE:

'BYRD'S NURSES ETHICAL SENSITIVITY TEST'

(BYRD'S NEST)

by

Lisa Marie Byrd

Abstract of a Dissertation
Submitted to the Graduate Studies Office
of The University of Southern Mississippi
in Partial Fulfillment of the requirements
for the Degree of Doctor of Philosophy

May 2006

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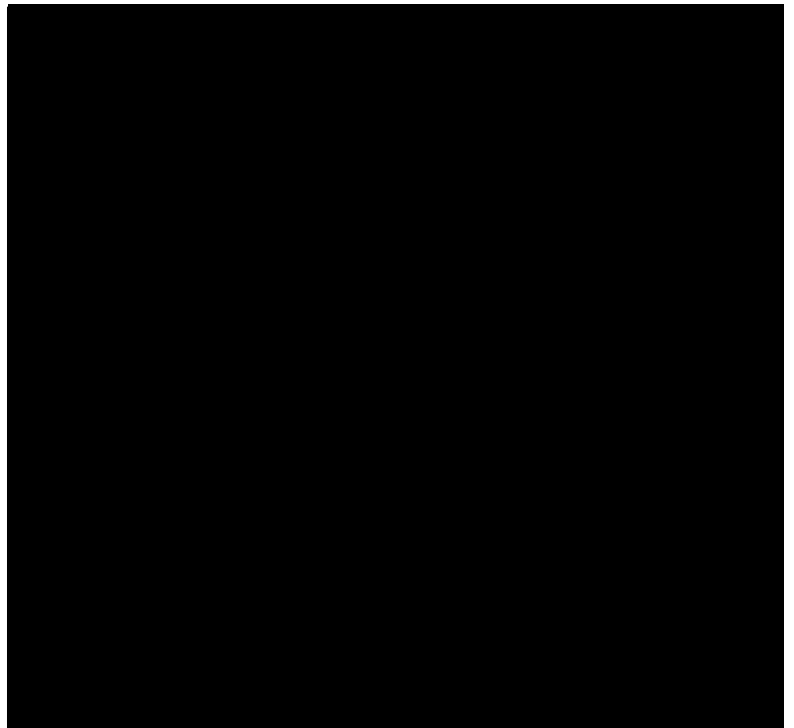
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Approved:



August 2006

ABSTRACT

DEVELOPMENT OF AN INSTRUMENT TO IDENTIFY THE VIRTUES OF
EXPERT NURSING PRACTICE:
'BYRD'S NURSES ETHICAL SENSITIVITY TEST'
(BYRD'S NEST)

by Lisa Marie Byrd

May 2006

The purpose of this research was to develop and analyze the psychometric properties of *Byrd's Nurse's Ethical Sensitivity Test* (Byrd's NEST). An instrument to evaluate nurses' ethical sensitivity in practice by examining choices of action in ethical dilemmas based on nursing virtues: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Benner, Tanner, & Chelsa, 1996; Volbrecht, 2002). Benner's theory of skill acquisition-novice to expert- was the theoretical framework for this research which surveyed for correlations between a nurse's ethical sensitivity and educational level, years of experience, certification, and work setting. Until now, there have been no instruments available to measure nurses' ethical sensitivity.

Instrument development was the focus of this research which employed multiple phases in creation and psychometric testing. The Byrd's NEST consists of 10 ethical dilemmas in nursing followed by three response choices to allow the participant to choose a course of action scored on a scale of low, medium, or high degree of ethical sensitivity. Concurrent

validity was assessed utilizing the Moral Sensitivity Questionnaire (MSQ) (Lutzen, Everton, & Nordin, 1997) and the Multidimensional Ethics Scale (MES) (Reidenbach & Robin, 1990). Reliability and validity tests were conducted throughout the study in three stages: first two panels of experts evaluated the instrument and scored the items, next a small pilot study of 20 nurses were administered the instrument and test/retest stability was examined, and finally a larger pilot study of 500 nurses was conducted through a one-time mail-out.

The scores in the large pilot study (N=115) indicated that all nurses who responded to this study demonstrated high ethical sensitivity regardless of educational degrees, years of experience, certification, or work setting. There was possibly a ceiling effect in which the different group's characteristics could not be seen. But these findings demonstrate that the nursing profession, as a whole, is an ethical practice. At this stage of development, the Byrd's NEST does not demonstrate internal consistency or concurrent validity with the MSQ or the MES items. The Byrd's NEST is in it's infancy and will require further revisions and additional testing to improve its reliability.

DEDICATION

This dissertation is to all nurses, those currently practicing, those who no longer practice, and those entering into nursing who make the profession an ethical practice and one in which I am proud to be a part. I also dedicate this dissertation to my family, my supporting husband, Ricky, and to my children, Joshua and Sarah, who have waited patiently for me to finish this endeavor.

ACKNOWLEDGMENTS

Sincere gratitude is extended to my dissertation committee members for their support and direction during this study. I especially thank Dr. Janie Butts, my research chairperson, who provided me with support, offered guidance, and helped me craft my ideas during this process. Janie and others at The University of Southern Mississippi (USM) in Hattiesburg helped instill the appetite for learning, one that is a life-long quest for knowledge which I will always value. I thank the committee members for their encouragement and belief in me while at USM. Dr. J. T. Johnson offered a great deal of input interpreting the statistics for this study. Dr. Lynn Chilton helped mold my ideas and went out of her way to travel to participate on this committee. Dr. Bonnie Harbaugh and Dr. Sherry Hartman offered support and guidance through this process. Without each and every member, I would not have been able to complete this project.

I thank Kim Lutzen and Eric Reidenbach for allowing me to use adaptations from their instruments as concurrent validity tests for this study. Both Lutzen and Reidenbach were very supportive of this endeavor and allowed permission without hesitation. I appreciate their knowledge and support in this project.

Above all, I thank and appreciate my family. Ricky, my husband, was always there and supported me even when it meant that I spent a great deal of time working on this project. My son, Joshua, and my daughter, Sarah, have provided emotional support and been patient while I was preoccupied or was working on this study into the wee hours of the night. I appreciate and cherish them all!

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CHAPTER I

INTRODUCTION

The purpose of this research was to develop and analyze the psychometric properties of Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST), (Appendix A). An instrument which is to be used to evaluate nurses' ethical sensitivity in practice by examining their choices of action in ethical dilemmas based on the nursing virtues as defined by Benner: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Benner, Tanner, & Chesla, 1996; Volbrecht, 2002). At the time of the conduction of the study, there were no instruments available to measure a nurse's ethical sensitivity or the virtues of nursing. A greater understanding of the virtues of nurses could lead to better nursing care in providing ethically-sensitive, morally-justifiable care that can be evidenced and measured by improved patient outcomes.

Virtues are the nurse's degree of moral or ethical expertise and are necessary for a nurse to provide ethically-sensitive care leading to more expert care. Benner et al. (1996) defined expert nurses as those who have an ability to engage in practical reasoning which relies on mature and practiced understanding, a perceptual grasp of the situation, and a nurse's possession of excellent moral sensibilities, also known as virtues. The goal of this research was to create an instrument that will evaluate nurses' ethical sensitivity based on the virtues associated with nursing practice.

The primary question for this research was: What are the psychometric properties of the instrument: Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST) (Appendix A). Additionally, other relationships that were examined were as follows:

1. The ethical sensitivity of nurses related to educational level in nursing;
2. The ethical sensitivity of nurses related to years of experience as a registered nurse;
3. The ethical sensitivity of nurses related to specialization in the field of nursing;
4. The ethical sensitivity of nurses related to the work setting of the nurse.

The development and psychometric testing of an instrument used to evaluate a nurse's ethical sensitivity in nursing practice based nursing virtues will ultimately increase the depth of knowledge in psychometric testing in nursing and in nursing ethics. Also, using the psychometric testing process will promote the development of methods to enhance expert nursing practice, which will ultimately lead to improved patient outcomes. The construction of Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST) involved multiple phases in the process of development, testing, and refinement to assess the instrument's psychometric properties. The Byrd's NEST instrument consists of 10 scenarios, which were developed by the researcher. An ethical dilemma in nursing is posed in each scenario followed by 3 multiple choice responses, which allowed the participant to choose a course of action. Each course of action, or multiple choice response, was scored on a scale of low, medium, or high degree of ethical sensitivity.

Background

Everyday nurses encounter ethical dilemmas and situations that have been created by the rapid technological advances in medical and nursing care and the complexities of the health care systems. When nurses enter professional practice, they are bound by strict standards of practice and codes of ethics (Johnstone, 2005). There is a crucial need for nurses to provide focused, ethically-sensitive,

and morally-justifiable care (Peterson & Seligman, 2004; McAlpine, Kristjanson, & Porocho, 1997). Bioethics and other related literature continue to reflect concern regarding nurses who exhibit behaviors that may not be ethical or ethically sensitive (Benner, Tanner, & Chesla, 1996; Corringan-Wandell, 2003).

Recognizing the importance of ethics to the discipline of nursing and the need to transmit ethical values to those within the nursing profession are vital to promote expert nursing practice (Smith, 2005). Expert moral behavior in nursing requires excellent moral sensibilities (a vision and commitment to good clinical and caring practices), perceptual acuity (the ability to identify moral issues in particular situations), embodied know-how, skillful engagement, respectful relationships with patients, families, and other members of the healthcare team, and the ability to respond to a situation in a timely fashion (Benner et al., 1996).

Some researchers have suggested that nurses do not always have a clear understanding of their role in situations arising in ethical dilemmas (Habel, 2005). Ethical situations and challenges that arise in a nurse's everyday practice are often sidelined, dismissed as ordinary, or not actually seen as *ethical* giving the appearance that the nurse's role in ethical decision making is devalued and typically inadequately recognized by the nursing profession (Phillips & Benner, 1994; Varcoe, Doane, Pauly, et al., 2004). Kelly (2000) emphasized that nurses are not even aware of the ethical decisions they may be making on a minute-by-minute basis because the ethical issues in nursing care are so omnipresent. There could also be misunderstandings about the importance of the nurses' role, as well as a powerlessness felt by nurses in ethical dilemmas, and a deficient

knowledge base about how to go about assisting nurses and/or patients in working through ethical dilemmas.

The teaching of ethics is not only necessary during the education process for nursing students but also for those nurses who are currently practicing. Education in ethics assessment needs to be included in the clinical setting because most ethical dilemmas seem to emerge from practice and new ethical dilemmas arise on a daily basis. Ethical issues that may not have been addressed during the educational process, or not been encountered at any point in their current career, may cause the nurse confusion and frustration in their working environment (Habel, 2005). Habel (2005) reported that several reviewed studies have indicated that nurses faced ethical decisions on a daily basis and that learning ways to manage ethical dilemmas would strengthen the nurse's role and encourage nurses to act appropriately and subsequently lead to more expert care.

Ethical decision making is inherent in nursing practice (Benner et al., 1996). Expert nursing practice is exemplified by improved patient outcomes and can be measured through research by studying outcome-based practice. Expert nursing practice is demonstrated by indicators showing improved patient care, decreased mortality rates, and more satisfied consumers—the patient, the family, and other healthcare providers (*Nursing*, 2004).

The Expert Nurse and Practical Wisdom

The practice of the expert nurse is characterized by the ability to engage in practical reasoning which relies on mature and practiced understanding, a perceptual grasp of the situation, and the nurse's possession of excellent moral sensibilities, also known as virtues (Benner et al., 1996). One of the ancient

virtues, practical wisdom or *phronesis*, is cultivated from character development and disposition, according to Aristotle, and is exemplified by people's virtues (Aristotle, trans. 2002; Peterson & Seligman, 2004). As a person's character develops, so does the person's cultivation of practical reason (wisdom), which, in turn, leads to excellent moral sensibilities and decision making. Ultimately the person, that being the expert nurse in the present case, performs competently by deliberating with others and pondering choices, by knowing what actions need to be taken in any given ethical situation, and by acting virtuously because of having developed the wisdom to do so. Benner (1996) rated the strong similarity of Aristotle's practical wisdom to the expert nurse's potential to make excellent decisions in ethical situations. Benner advocated that the development of clinical expertise demands the development of moral or ethical expertise. Benner, Hooper-Kyriakidis, and Stannard (1999) believed that for nurses to acquire ethical expertise, they must learn to respond to ethical situations in the way expert nurses would respond in that same situation. Building an environment that supports the nurse's development of virtues possessed by expert nurses will have a favorable influence on patient care and patient outcomes (Corringan-Wandall, 2003).

Nurses play a valuable and critical role in ethical decision-making in the healthcare arena. Nurses are often present with patients and families when decisions regarding care are made. There have been numerous studies conducted and many articles and books written about ethics in healthcare, some specifically about nursing ethics, but no studies have been conducted using a quantitative instrument to measure ethical sensitivity in nurses. There are some qualitative studies that are composed of open-ended questions for investigation

into ethical practice in nursing but these are limited studies that do not offer a broader understanding of nursing practice. Though studies that are qualitative have laid the groundwork for understanding the basic principles of virtues in nursing; larger studies are necessary to more closely connect ethical theories to everyday nursing practice. Research findings that relate to ethical sensitivity in nurses are of value to registered nurses, hospitals, facilities, and teaching institutions. One way that this type of investigation can be furthered is by creating an instrument to identify the degree of ethical sensitivity in nurses based on the virtues as defined by Benner (Dodd, Jansson, Brown-Saltzman, Shirk, & Wunch, 2004).

Most psychology researchers agree that development of character strengths, or virtues, develop across a person's lifespan and seek to understand this development by examining settings and cultures where positive virtues are displayed. This is sought after to encourage positive virtues in others (Peterson & Seligman, 2004). Examining the choices made by nurses will identify positive virtues and create a link to variables which lead to development of these positive virtues. This process will identify ways to create environments that encourage nurses to demonstrate positive behaviors and become expert nurses.

Problem

No instruments were found in the literature that identified ways to assess ethical sensitivity of registered nurses in nursing practice. Ethics and ethical decision-making are key concepts for attempting to understand expertise in practice (Smith, 2005). Benner has conducted extensive work by investigating the skills of nurses—discovering the stages of professional development of nurses

starting with the novice nurse and culminating at the peak of nursing and the expert nurse (Benner et al., 1996). Expertise in nursing is gained through education and experience. Ethical behaviors in nursing are influenced by educational level in nursing, years of experience as registered nurses, specialization in fields of nursing, and the work environment of the nurse (Benner et al., 1996). To achieve a high level of practical reasoning, critical analysis skills, and ethical decision-making ability according to Benner et al. (1996), expert nurses should have strong, well-intentioned behaviors, and good character traits, or what Aristotle (trans.2002) called virtues.

It is essential that nurses recognize the existence of virtues in nurses, which are critical to providing excellent ethical decision-making in expert nursing practice. Expert nurses will then have the ability to help positively influence nursing practice and care by appropriately articulating the expectations of how nurses should respond in ethical situations. Developing or modifying current approaches to ethical practice and creating a reliable and valid instrument to measure ethical sensitivity of nurses based on the virtues as defined by Benner would be a first step of study in a long process of developing and understanding nursing virtues in clinical practice.

Purpose of the Study:

Psychometric Test of the Byrd's NEST Instrument

The purpose of this study was to develop a conceptually sound instrument to assess ethical sensitivity in nursing practice based on the virtues as defined by Benner (1996) and to test the psychometric properties of the Byrd's NEST. Instrument development was the focus of this research which employed multiple

phases in creation and psychometric testing. Reliability and validity tests were conducted throughout the study in three stages. The sample populations were surveyed for correlations between a nurse's ethical sensitivity and educational level, years of experience, certification, and work setting.

Research Question

The research question for this study was:

1. What are the psychometric properties of the proposed instrument Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST)?

Additional data analyzed were as follows:

1. Is there a relationship between the ethical sensitivity scores of nurses and educational level in nursing?
2. Is there a relationship between the ethical sensitivity scores of nurses and years of experience as registered nurses?
3. Is there a relationship between the ethical sensitivity scores of nurses and specialization in fields of nursing?
4. Is there a relationship between the ethical sensitivity scores of nurses and the work setting of the nurse?

Conceptual Framework

The theoretical framework for this study was based on Benner's (2001) theory which explains levels of proficiency in skill acquisition of nurses. Benner emphasized that nurses move through different levels of efficacy from novice to expert as they advance their knowledge and develop their skills. Further, intentions, expectations, meanings, and outcomes of expert nursing practice can be described and aspects of expert clinical skills can be captured.

Benner (2001) based her theory on the Dreyfus model, believing that a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert. These five levels reflect changes in three general aspects of skill performance and ethical thinking. The first aspect is a movement from reliance on abstract principles to incorporating concrete experiences into practice. The second aspect is a change in the learner's perception of a situation, from a collection of equally relevant bits of information to a compilation of parts that are relevant to the situation to create a whole picture. The third aspect is a passage of a detached observer to an involved performer where the individual no longer stands outside of a situation but is engaged in the situation.

The first level of nursing is the novice nurse who has no experience in situations which he/she is expected to perform (Benner, 2001). These nurses are taught about situations in terms of objective attributes such as vital signs, weight, intake and output, and other objective measures of a patient's condition. Novice nurses are taught context-free rules to guide actions and function under a rule-governed behavior, which is extremely limited and inflexible. Nursing students enter every new clinical situation as a novice and further their understanding of the contextual meaning of the recently learned textbook terms, not realizing the ethical intricacies of a situation.

The second level of nursing is the advanced beginner nurse who demonstrates marginally acceptable performance and has coped with enough real life situations to note (or to have pointed out by a mentor) the recurring meaningful and ethical situational components (Benner, 2001). These nurses still require

guidance in working through complex situations or ethical dilemmas. The advanced beginner can formulate plans of care according to principles with direction from a more experienced nurse who dictates actions and assists in developing guidelines to follow. The guidelines integrate as many attributes and aspects of a situation as possible, but they tend to ignore their differential importance, that is they treat all attributes and aspects as equally important. Novices and advanced beginners do not fully understand new situations or the complexities of the ethical components of the situation because most aspects of the situation are strange and unfamiliar in which these nurses must concentrate on remembering the rules and standards of care that they have been taught.

The third level is the competent nurse which is typified by a nurse who has been in the profession of nursing, in the same or similar situations, for two or three years and develops when the nurse begins to see their, or other's, actions in terms of long-term goals or plans (Benner, 2001). Plans of care dictate the attributes of current and contemplated future situations which are to be considered most important and which can be ignored. Competent nurses still lack the speed and flexibility of the proficient nurse but exhibit a mastery of skills and an ability to cope with and manage many changing situations. Conscientious and deliberate planning helps the competent nurse achieve efficiency and organization. Competent nurses begin to grasp the meaning of ethics in difficult situations.

The proficient nurse is the fourth level and is exemplified by a nurse who perceives a situation as a whole entity rather than in terms of individual attributes or aspects, and performance is guided by maxims (Benner, 2001). At this stage, the nurse learns from experience the type of events to be expected in a given

situation and the plans that need to be modified in response to specific circumstances. Based on experience, proficient nurses recognize the expected normal picture and when alterations have occurred. Decision making is less labored because proficient nurses now have a perspective on the many attributes and aspects of a situation that are important. Certain aspects stand out to proficient nurses as being more or less important for a particular situation. Proficient nurses use maxims as guides but at the same time have a deeper understanding of a situation. This understanding is required before a maxim can be used so that a better grasp of the ethical components of the situation can be captured.

An expert nurse, the fifth level, no longer relies on an analytic principle (rule, guideline, or maxim) to understand a situation and its appropriate action (Benner, 2001). Through intuition, expert nurses grasp the meaning of each situation and are able to focus in on the accurate region of a problem without wasteful consideration of a large range of alternative diagnoses and solutions. Highly skilled nurses are also able to function in difficult situations in which they have no previous experience because of their fluent analytical skills. A definitive description of expert nurses is difficult but these nurses demonstrate an understanding of the complex ethics involved in many situations.

As a nurse advances through the five levels of proficiency, many experiences are encountered. Experience is not quantified by mere passage of time in the nursing profession; rather it is developed through encounters with many actual situations (Benner, 2001). Not all nurses advance to an expert level, nor do

they possess certain virtues or demonstrate ethical behaviors in managing ethical dilemmas.

An expert nurses' attributes in practice regarding ethical issues often goes unnoticed and undocumented. An expert nurse who has a variety of experiences in dealing with ethical dilemmas has a rich knowledge base from which to expand and interpret new situations. There are many complexities to deciding upon the appropriate actions expert nurses choose when managing ethical dilemmas. It would be advantageous to the nursing profession to develop an understanding of nursing virtues by observing what course of action an expert nurse would pursue in ethical dilemmas.

Definition of Terms

Development of an Instrument

Theoretical

Development of an Instrument is theoretically defined as the creation and evaluation of a new instrument through application of psychometric theory and testing.

Operational

Development of the proposed instrument, Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST), is operationally defined as the creation of a new instrument to investigate the ethical sensitivity of nurses based on the virtues scores of registered nurses. The psychometric properties of the Byrd's NEST instrument were tested for reliability and validity by multiple methods of testing.

Registered Nurse

Theoretical

Registered Nurse is theoretically defined as a person who has completed a program of study which has enabled the individual to take the board examination to be a registered nurse, passed the board examination to be a registered nurse, and is currently practicing in the field of nursing.

Operational

Registered Nurse is operationally defined as a person who has completed a program of study which has enabled the individual to take the board examination to be a registered nurse, passed the board examination to be a registered nurse, is currently practicing in the field of nursing, and responded to this survey.

Virtues

Theoretical

Virtues are theoretically defined as attributes or characteristics necessary for one to make ethically appropriate decisions in nursing practice. Specifically, Benner has defined 8 virtues of expert nurses: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity.

Operational

Virtues are operationally defined as attributes and characteristics that are measured by the Byrd's NEST instrument to assess ethical sensitivity of nurses by determining what actions nurses would take in a particular scenario and comparing/contrasting the actions of nurses at various stages of professional development.

Expert Nurse

Theoretical

Expert nurse is theoretically defined as one who has worked in the same specialty within the nursing profession several years and no longer relies on analytic principles (rules, guidelines, maxims) to understand a situation and its appropriate action (Benner, 2001). There is an intuitive grasp of each situation and the expert nurse is able to zero in on the accurate region of a problem without wasteful consideration of a large range of alternative diagnosis and solutions. Highly skilled nurses are also able to function in situations in which they have no previous experience due to their fluent analytical skills. A definitive description of an expert nurse is difficult due to the complexities of this individual but these nurses demonstrate an understanding of the complex ethics involved in many situations.

Operational

Expert nurse is operationally defined as individual who is a registered nurse, has worked in the same field of nursing for a minimum of 10 years, and has shown efforts to increase their nursing knowledge through advanced educational degrees and/or passed certifications for specialty practice in nursing.

Ethical Sensitivity

Theoretical

Ethical Sensitivity is theoretically defined as the ability for one to recognize a situation as an ethical dilemma and to choose the action that is considered appropriate.

Operational

Ethical Sensitivity is operationally defined as the appropriate action a nurse would choose in the ethical decision-making process in a specific situation as presented in the Byrd's NEST.

Ethical Sensitivity Scores

Theoretical

Ethical sensitivity scores are theoretically defined as scores obtained by surveying nurses.

Operational

Ethical sensitivity scores are operationally defined as the actual scores obtained from nurses' responses to items on the Byrd's NEST instrument-10 scenarios presenting ethical dilemmas in nursing practice. An ethical dilemma in nursing is posed in 10 scenarios followed by 3 multiple choice responses to allow the participant to choose which course of action they would pursue in the dilemma. Each response or choice of action is scored on a scale of low, medium, or high degree of ethical reasoning. For each scenario low will score 1, medium will score 2, and high will score 3. There is a possible total score of 10 to 30 for the Byrd's NEST. A total score of 10 to 16 will be equivalent to low ethical sensitivity, 17 to 23 will be equivalent to medium ethical sensitivity, and 24 to 30 will be equivalent to high ethical sensitivity.

Validity

Theoretical

Validity is theoretically defined as the ability of a test to measure the construct it seeks to measure.

Operational

Validity is operationally defined as the ability that the Byrd's NEST instrument will measure an expert nurse's moral or ethical expertise. This includes test validity and face validity by a panel of experts.

Reliability

Theoretical

Reliability is theoretically defined as the results of the sampling to yield consistent results.

Operational

Reliability is operationally defined as the results of the sampling to yield consistent results.

Internal Consistency

Theoretical

Internal consistency is theoretically defined as the degree to which test items are consistent across the instrument.

Operational

Internal consistency is operationally defined as the extent to which test items are consistent across the instrument.

Test/re-test reliability (stability)

Theoretical

Test re-test reliability is theoretically defined as surveying a sample with an instrument initially and repeating the same survey in a specified period of time to establish reliability and stability of responses to the survey.

Operational

Test re-test reliability is operationally defined as surveying a sample with an instrument initially and repeating the same survey approximately two weeks later to establish reliability and stability of responses to the survey.

Assumptions

The assumptions for this study were as follows:

1. Nurses have the best interest of the patient in mind when providing nursing care.
2. Registered nurses who complete and mail the survey answered honestly and that the responses were reflective of their practice.
3. Psychometric testing of the instrument established some level of validity and reliability of the proposed instrument, the Byrd's NEST.

Limitations

The limitations for this study were as follows:

1. The Byrd's NEST results may not be reflective of all ethical nursing virtues.
2. Registered nurses who participate in this survey may have been inclined to respond in a way that is not reflective of their actual nursing practice. In other words, they may have answered the way they think the researcher wanted them to respond thus creating a threat to validity called social response bias.

Significance of the Study

Developing a sound instrument to assess ethical sensitivity in nurses based on the virtues as defined by Benner (1996) will forward the nursing professions' understanding of ethical nursing practice. The documentation of validity and

reliability will help to lead to the development of a psychometric instrument that may be used to assess ethics in nursing practice leading to an understanding of expert nursing practice. Expert nursing practice needs to be understood, so that morally-sensitive patient care is enhanced, ultimately leading to improved patient outcomes.

Summary

The purpose of this research was to develop and analyze the psychometric properties of the proposed instrument, Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST). This will be an instrument that can be used to measure ethical sensitivity in nursing practice based on the virtues as defined by Benner (1996). There was additional documentation examining if there were relationships between the ethical sensitivity scores and educational level in nursing, years of experience as registered nurses, specialization in fields of nursing, and the type of work environment of the nurse. The construction of the Byrd's NEST instrument underwent multiple phases in the process of development, testing periods, and refinement to assess the instrument's psychometric properties and improve the instrument.

CHAPTER II

REVIEW OF LITERATURE

In order to fully understand the importance of ethics in nursing practice, it is imperative to provide a discussion of virtues, virtue ethics, and the historical development of virtue ethics. This will include views opposing use of virtue ethics and opinions of its proponents. An argument for applying virtue ethics to nursing practice as well as a discussion of the American Nurses' Associations *Code of Ethics* will be presented. A review is offered to explore research in the virtues of nursing that includes a list of virtues that have been associated with nursing. There are extensive references to Patricia Benner, a nursing theorist, and Edmund Pellegrino, a medical theorist, who both wrote extensively about virtues and their importance in nursing and medical practices.

Bioethics is the examination of moral and ethical dilemmas encountered in the delivery of healthcare. There is a crucial need for nurses who are able to provide ethically-sensitive, morally-justifiable care (McAlpine, Kristjanson, & Porocho, 1996). Ascertaining the decision making processes of nurses who encounter ethical dilemmas is important to understanding what is considered expert nursing practice which leads to improved patient care and improved patient outcomes. Understanding how expert nurses choose to act in situations which are ethically problematic will assist in understanding expert nursing practice. Benner, Tanner, and Chesla (1996) defined expert nurses as those who have an ability to engage in practical reasoning which relies on mature and practiced understanding, a perceptual grasp of the situation, and a nurse's possession of excellent moral sensibilities, also known as virtues. Virtues are the

nurse's degree of moral or ethical expertise. Virtues are exemplified by expert nurses in nursing practice.

One way to develop an understanding of the ethical decision making process of nurses is to develop a psychometric instrument that analyzes the ethical sensitivity of nurses. There are no instruments designed to examine the ethical sensitivity of nurses in ethical dilemmas. A search of literature was performed utilizing CINAHL, The University of Southern Mississippi (USM) Library search, Georgetown University Bioethics Library search, and a search of Dissertation abstracts 1861-present with no instruments found. The question of a definition of nursing virtues was asked on a nursing internet METRIC message board-a forum for nurses to ask colleagues and experts in the field questions about nursing and the profession. The only reply was from a nursing expert - Elizabeth Martin - who suggested investigating this topic under nursing measures of caring. The additional suggested search did not discover any instruments that were available to analyze the unique ethical decision making of nurses.

Virtue

Virtue is a concept that is inherent to understanding morality. Virtue is the most ancient, durable, and ubiquitous concept within the history of ethics (Pellegrino, 1995). Plato advanced the idea of virtue through the dialogues of Socrates (Pellegrino, 1995). The first idea was an excellence in the knowledge of good which disposes one to a good and moral life and to happiness (Pellegrino, 1995). Throughout his dialogues, Plato develops a list of characteristics that describe a virtuous person: one who has temperance, demonstrates justice, exemplifies wisdom through self-restraint, and acts with fortitude (Pellegrino,

1995). Virtue is not a 'habit' in the sense of being an unconscious reflex. Rather a habitus, a predictable disposition to choose good in any given situation (Pellegrino, 1995). Virtuous persons choose good for the sake of good and these persons must choose good because of their innate character. Choosing to do good and the right thing will ultimately lead to happiness. Vice is the opposite of virtue and originates from the ignorance of good or morality (Denise, White, & Peterfreund, 2002).

Virtues are the basis for an ethical society because they dictate how society measures the morality of actions. One cannot separate the character of a moral agent from his/her actions, the nature of those actions, the circumstances surrounding those actions, and the consequences resulting from those actions (Pellegrino, 1995). Virtue theories focus on an agent, the intentions, dispositions, and motives which lead to an understanding of the very individual whose actions are the result (Pellegrino, 1995).

A moral person is a good person upon whom one can rely to act in certain ways in certain situations, one who will habitually act good or moral under all circumstances (Pellegrino, 1995). This creates a circular logic that holds that a virtuous person will act in a moral and good manner and one who acts in a virtuous manner is one who is right and good. Society dictates what is acceptable and what is not so it must be acknowledged that as societies change, the values of those societies change and what is moral or virtuous for one society may not be moral or virtuous for another. This may sound like a relativistic view but one must remember, according to virtue ethics actions cannot be taken out of context and be understood by all societies; actions cannot be taken from their time and universalized to another time.

Virtue Ethics

Virtue ethics in nursing is a noble and righteous idea but the difficulties involved in defining morality and virtue must be acknowledged and addressed. If virtue is to be restored to normative status, a strong case must be presented. Pellegrino (1995) insists that any normative theory of virtue ethics must include three concepts: (a) a theory that defines the telos or the good of an activity, (b) a definition of virtue in terms of that theory, and (c) a set of virtues that characterizes a *good* individual. Virtue theory is grounded in discussing the three phenomena encompassed in a healing relationship that healthcare professionals maintain with their patients: the fact of illness, the act of the healthcare profession, and the act of healing (Pellegrino, 1995). The key components of a sound virtue-based theory include a discussion of benevolence, trust, compassion and caring, prudence, and justice (Pellegrino, 2003).

Every culture has a notion of the moral person - that is a paradigm person, real or idealized, who sets the standards of noble conduct for society and whose character traits exemplify the kind of person others strive to be (Pellegrino, 1995). These idealistic characters are celebrated in myths and stories, in poetry and ritual and their moral values and characteristics are discussed in the philosophy and theology of different eras and cultures (Pellegrino, 1995). They have been formalized in the works of Plato and Aristotle (Pellegrino, 1995), in the philosophy of Confucius (Cua, 1978) and Lao Tse (Yearly, 1990), and in the Hindu concept of Dharma (Jhingran, 1989). These paradigm figures are exemplified through characters, such as Jesus, Buddha, and Confucius whose values and beliefs created the highest standards of what it is to be a good human being (Pellegrino,

1995). The intricacies and relationships of these moral or virtuous persons, and the societies in which they lived, created models of moral life for others within those societies to strive to emulate. According to Pellegrino (2003), humans want to be moral, strive to be moral, and can be moral. To understand what it is to be moral, virtue theories must be explored and there are certain concepts which must be examined.

Historical Perspective of Virtue Theory

Notions of virtues and good can be traced to writings of Plato in 400 B.C., who elaborated on Socrates' four cardinal virtues of wisdom, courage, temperance, and justice (Pellegrino, 2003). Aristotle continued this discussion, arguing that a virtuous person is one who lives according to reason, thus realizing one's own potentiality (Thomson, 1962). He divides human virtue into two categories: the moral and the intellectual. Moral virtues concern the choice of actions which become habits and these are in accordance with one's rational principles (Thomson, 1962). Further, contemplation of truths and discovery of the rational principles that one ought to follow, give rise to the intellectual virtues (Thomson, 1962). It is through acting morally that one becomes moral just as it is for a cook to learn to cook that one becomes a cook, one becomes just by doing just and brave acts (Thomson, 1962). And when one becomes moral through this type of habituation, one rationalizes morally, thinks morally, and is inclined to act morally in all aspects of their life.

Aristotle did acknowledge that certain things ought never be done - that is adultery, murder, and theft-and that certain dispositions ought never be adopted- spite and envy (Pellegrino, 1995). With the exception of those acts and

dispositions, practical wisdom adopted by societies dictates what is considered moral and good. But what is right and good, what is the virtuous thing to do, and what is a virtuous person? These issues become especially clouded in healthcare because of the advances in technology where discussions lead to new territory where there are no established right and wrong actions.

Thomas Aquinas has been referred to as the Plato of the Middle Ages (MacDonald & Stump, 1999). Aquinas agreed with Aristotle's account of moral virtues - that humans can choose their actions and that those actions are deliberate, leading to advocacy for free choice (MacDonald & Stump, 1999). One who has good character is one who patterns habits of choice in accordance with principles that are wise, derived from careful thought and analysis of facts and opinions (MacDonald & Stump, 1999). People bear responsibility for their choices unless they are physically forced to an action or are ignorant about what their actions involve when that action is not good or moral (MacDonald & Stump, 1999).

Aquinas' analysis of the moral worth of voluntary acts involves three parts that are morally relevant: the type of act that it is, the motive that prompts the act, and the consequences of that act (MacDonald & Stump, 1999). Examining these three features leads to an understanding of the measure of goodness or morality of that act and the degree of virtue that act entails (Denise et al., 2002).

The British political theorist Michael Oakeshott argued that a moral society is one which acts chiefly out of 'a habit of affection and conduct'; that is moral decisions are not the product of reflective thought, nor are they made by applying a moral ideal or principle to a particular situation (Pellegrino, Veatch, & Langan, 1991). Rather, society acts from habits of behavior-habits taken for granted and

inculturated into the young or the novice of society (Pellegrino et al., 1991). Moral life is a way of life that is learned, habits of conduct are acquired through seeing people habitually behave in certain ways, and from being initiated into a tradition of conduct (Pellegrino et al., 1991).

Bishop Joseph Butler grounded morality in his ethical theory: conscience is conceived as a reflective or rational faculty, based upon moral reason, and discerns the moral character (Denise et al., 2002). Moral obligations are only valid if they run in congruence with the way people are, by nature, capable of acting; that each person finds within him/herself the rules of right and morality (Denise et al., 2002). And thus, people are obligated to follow these rules of moral conduct.

Benner believed that individuals are obligated to act morally, basing strong moral mandates on respect for others' dignity and rights (Phillips & Benner, 1994). She advocated that nursing was a profession with all the attributes for restoration of virtue ethics into practice (Thomasma, 1997). This entails an obligation for respecting others by understanding what constitutes a good life and what constitutes human dignity and acting accordingly (Phillips & Benner, 1994).

Gilligan advocated that women have different moral concerns than men, noting that a feminine viewpoint sees the moral person as one who is sensitive to the needs of others (Gordon, Benner, & Noddings, 1996). In responding to the needs of others, relationships are created so that one individual can do good for another. Morality emphasizes responsiveness and responsibility in relationships with an individual first and then with society (Gordon et al., 1996). Carse stresses impartiality being present with all of these relationships for individuals to be truly moral (Gordon et al., 1996). The essential feature of a moral person is one who

attends to the needs of others, taking into account the circumstances that surround these caring relationships and entering relationships with patients that may be heavily one-sided where the nurse takes on the more active role (Gordon et al., 1996).

Other world views must be taken into account when speaking of morality and virtue. Judaism advocates that those who were virtuous were those who practiced moderation and prudence, justice and fortitude (Pellegrino, 2003). Other virtue based philosophers surfaced in the Far East such as Confucius who spoke of benevolence, sincerity, and defined a virtuous person as one who looks straight into the heart and acts well when alone (Pellegrino, 2003). Lao Tzu preached tolerance, simplicity, and unselfishness as the attributes of a virtuous life (Pellegrino, 2003). And finally, Mencius' teachings speak about humans being as being inherently good and moral (Pellegrino, 2003).

Opposing views

In the post-Medieval and post-Enlightenment periods to the present day, metaphysical foundations for morality and virtue ethics, such as those discussed, have been scrutinized and have been under attack by a variety of forces (Pellegrino, 1995). Beginning with the Enlightenment Period, the possibility of a metaphysical definition of human nature, or good and morality, were subjected to skepticism and denial, questioning the religious authority and human reasoning that defended morality (Pellegrino, 1995). Hobbes and Locke replaced these ideas with realism about the dubious nature of human motives and conduct (Pellegrino, 1995).

Hobbes insisted that no action was intrinsically good, rather people call actions good when they desire them to be good (Hampton, 1988). He told us that a social contract is necessary and sufficient for morality to be present (Hampton, 1988). Whatever is in accordance with the law is right or moral and whatever deviates from it is wrong (Hampton, 1988). Thus civil authority and law is established as the foundation of morality. Human beings are not inherently moral or good, it is society which determines if one is moral or good.

Like Hobbes, John Locke views good as defined by society. Morality or good is that which causes pleasure and diminishes pain; evil is that which causes pain and diminishes pleasure (MacIntyre, 1998). Moral good is the conformity of our actions to law which has been determined by society. Locke views mankind as human beings living in families and those families living in societies and there being a social order within these societies (MacIntyre, 1998). Human beings have certain natural rights including liberty and the right to make decisions upon the actions they make. Thus it is desirable in society to create an authority to adequately safeguard everyone's natural rights, since Locke believed that human beings are not inherently moral and may infringe upon the rights of others (MacIntyre, 1998).

Kant believed the universal basis of morality lies in a person's rational nature and this is the same in every individual (Baron, 1999). A moral principle is one that dictates all people should act in a certain manner, including 'oneself' (Denise et al., 2002). Against the background of 18th century skepticism, Kant uses the test of consistency as the fundamentals of moral laws which he calls 'categorical imperatives': those actions are right if they confer to principles that can

be applied to everyone, and those actions wrong that if they are based on principles that a rational person could not apply to everyone, all the time (Baron, 1999).

Nietzsche (1967) thought virtue was a weakness unbecoming of the ultimate being one should strive to be, the Superman. He rejects the notion of morality and believes that man advances in the evolutionary process by an aggressive 'will of power' to dominate his peers and his environment (Mangus & Higgins, 1996). This evolutionary process that Nietzsche spoke of was not a biological process but a developmental process that societies advance through, as the strong beat out the weak within a society, the strong will dictate what is considered right and good (Mangus & Higgins, 1996). True morality is built upon power derived from the need to dominate, a characteristic that all possess (Mangus & Higgins, 1996).

Marxism says morality is meaningless (McMurtry, 1978). Society determines what is right and good (McMurtry, 1978). Leaders of society are those who have material goods and thus it is they who determine what is moral and good. Morality is not inherent within individuals but is determined by those who rule and changes as society changes.

In opposition to virtue ethics, Hume believed that all people have the same psychological makeup and their moral responses *could* be comparable (Reck, 1983). Society judges what is considered moral and it is they who judge an individual's actions as being moral or not. He further insisted that the study of an individual's moral behaviors will reveal the inherent morality of a person (Reck, 1983). Morality is practical, thought out through reason, and influences one's

conduct (Reck, 1983). Though reason is incapable of being the sole source of morality, it plays an essential role in the rendering of moral decisions (Reck, 1983).

Virtue as a trait has been attacked on many fronts throughout history. Virtues were replaced by duty for Kant, moral sentiment by Hume and Smith, and consequences and utility by Bentham and Mill (Becker & Becker, 1992). Machiavelli (1970) also maintained that the world was full of people who were not virtuous, dooming those who were virtuous to be preyed upon by those who were not. Ayn Rand (1964) condemned the conception of virtue as inimical to the ethos of success.

Not everyone believes there is such a thing as morality. For those who do believe in morality, there are multiple definitions of what is virtuous and moral. There are no clear cut guidelines that define what constitutes morality thus making the definition subjective. This leads to an inclination to call morality a relativistic notion (Pellegrino, 2003). Moral conclusions are verified by some as merely a matter of perception. These are some of the shortcomings of any virtue-based theory (Pellegrino, 2003).

Morality in Contemporary Times

Morality is a vital notion-it is relevant, complex, universal, durable and inescapable (Pellegrino 2003). Morality does exist. It can be learned, it can be demonstrated, but it cannot be defined. The difficult task is to determine what morality is, how it can be applied, and what the virtues of morality entail in a society which has pluralistic views about this very subject.

Some people identify the moral person as one who is responsible, law-abiding, and lives a decent life (Ashley & O'Rourke, 2002). A person's moral

identity is the best predictor of commitment to practicing everyday life with moral integrity (Doane, 2002). The ability to navigate through complex, ambiguous, and shifting terrain of ethical dilemmas gives an individual the ability to actively narrate their responses through decision making and actions in relation to values that can support an evolving identity as a moral agent (Doane, 2002). It is easy to act morally or good when it is convenient and one does not suffer any consequences for choosing to act morally or good. But it is when an individual acts morally in difficult situations that demonstrate a truly moral person.

Pellegrino (1995) revived the idea of morality and virtue as an excellence in traits of character, as a trait orientated to ends and purposes, as an excellence of reason not emotion, centered on practical judgment, and learned by practice. Virtues have normative force not because they are agreeable or admired but because they predispose human beings to the ends, purposes, and good or morality as defined by an underlying metaphysics (Pellegrino, 1995).

MacIntyre (1984) has built on the Aristotelian notion of virtue and defined it in contemporary terms taking into account the erosion of tradition and the moral consensus that had previously given this classical doctrine its strength. He has regarded virtues as qualities that are necessary to achieve good, necessary to sustain communities, and essential to sustain tradition (MacIntyre, 1988). Virtue is a character trait necessary to achieve excellence (MacIntyre, 1988). Thus MacIntyre adopts the teleological view of the Aristotelian virtue but adds the sustaining force of a historical community of values (Pellegrino, 1995).

Virtue is a trait of character that predisposes one to habitually act to excellence of intent and performance with respect to the end (telos) (Pellegrino,

2003). Virtue is demonstrated by good individuals and makes those individuals moral. Not all people are moral, virtue is not an inherent trait but it is a trait that most in society want to attain. Virtue ethics is the oldest tradition in the professional ethics of medicine and nursing as proclaimed by the Hippocratic Oath and as integrated in Nightingale's Pledge (Pellegrino, 2003).

MacIntyre (1984) has successfully reformulated morality and the virtues inherent in being moral into contemporary terms. This definition contains three elements that see virtues as acquired qualities and dispositions; they are (a) necessary to instill good to practices, (b) necessary to sustain societies who strive for a higher good than good within each individual's own life, and (c) necessary to sustain traditions that provide the settings for individuals to live in a society that is just (Pellegrino, 1995). Virtue is necessary for one to be moral and thus is a trait to be seen, learned, and perfected if society is to be moral (MacIntyre, 1984).

There are difficulties that arise from MacIntyre's definition such as the absence of a shared notion of good or a society who will sustain this notion (MacIntyre, 1990). Murdoch (1992) also recognized the need for and the difficulties in recovering the conception of a generally accepted good as the foundation for moral life and of the virtues. She insists that the idea of good is enveloped by a religious connotation and since we live in a pluralistic society which has many different religious views of morality and goodness, there are many difficulties in fully and clearly understanding what it is to be a moral and virtuous person (Pellegrino, 1995). Without moving toward a discussion pertaining to religious ideals, it must be noted that the philosophical and theological components of virtue increases the difficulties of a contemporary revival of a general morality theory.

The society in which we live has developed ideas of pluralism, relativism, and privatized the morals of individuals which leave little hope for an agreement on the definition of a virtue-based ethics system (Pellegrino, 1995). An acceptance in the decline of virtues in the health professions by society may have come about due to a heightened distrust of authority (Pellegrino, 1995). Character failings some health care professionals have exhibited has shifted public attention on autonomy-based, contractual relationships rather than on trust-based, conventional ones (Pellegrino, 1995). This has led to the difficulty society has in defining what virtues should characterize a 'good' healthcare professional.

Nursing

Sickness, pain, and death occur on a daily basis. Those who enter nursing must tread these waters daily, enter a world where every word they say and every action they perform can cause the saving of a life, the hastening of a death, the comfort of one in pain, or the hurt of one who is alone. Therefore care must be integrated into the very heart of nursing. Should those who enter nursing, where they must make life and death decisions on a daily basis, be expected to act virtuously in each and every decision they make? Incorporating a caring aspect into everyday practice makes individuals become moral agents and to act with an ethic that mandates the actions that must be followed. People are not innately moral or virtuous and cannot be forced to be virtuous. Professional ethics must be examined in an attempt to characterize the obligations of nursing professionals. And thus state the domain of duties, obligations and virtues entailed in this type of healing relationship (Pellegrino, 1995).

When people graduate from nursing programs, they earn a degree that declares they are educated but they are not yet in the profession (Pellegrino, 2003). To become a professional, one must have the knowledge and declare that knowledge or use that knowledge to the interest of others (Pellegrino, 2003). That professional is dedicated to something other than their own self-interest due to the special nature of the healer relationship a healthcare provider undertakes.

Morality within the health care professions involves helping those entering the profession to understand and accept their professional responsibilities as constant and overriding and to understand the principles of morality and ethics that are relevant to health care practices (Rhodes, 2002). Novice practitioners must be taught the skills to be able to understand moral principles and understand how to apply them in difficult situations.

Morality is not clearly defined and thus cannot be placed in a table to be memorized. Acts cannot be understood without knowledge of the inner character or intention of the actors (Smith & Godfrey, 2002). One learns to act virtuously or morally by seeing good actions. Character and values precede conduct and virtue is a trait based on reason, not emotion, centered on practical judgment, and learned by practice (Smith & Godfrey, 2002).

Many nurses want to do the right thing but need encouragement and reinforcement (Pellegrino, 2003). Human nature does have defects and not everyone will behave in a virtuous manner. But nurses do the best they can and this helps create a conscience within the individual and within society to have a society where ideas of morality are practiced.

Virtue is a character trait developed by a good nursing professional which disposes that individual habitually to have moral or good intent and act upon this intent to accomplish a good or virtuous end (Pellegrino, 1995). These dispositions are internal to the practice of nursing and impart the nursing professional to heal well (Pellegrino, 1995).

The key components of a sound virtue-based theory include a discussion of benevolence, trust, compassion and caring, prudence, and justice (Pellegrino, 2003). Benevolence is a virtue that intends the nursing professional to do good since a patient obviously seeks to be helped and not harmed (Pellegrino, 1995). Trust is a virtue that is ineradicable to the healing relationship because ultimately a patient has no choice but to trust the nurse, they come in a time of need and have certain expectations of their provider (Pellegrino, 1995). Compassion and caring enables the nursing professional to feel something of the patient's experience of the predicament of an illness (Pellegrino, 2003). Compassion is the prelude to caring-to developing concern, empathy, and consideration of a patient's plight (Pellegrino, 1995). Acknowledging when one has the knowledge and skills to help an illness and being humble enough admit ignorance is an integral part of this healing relationship. Prudence is practical wisdom that utilizes the skills of deliberation and discernment to make decisions in situations of uncertainty and stress. And commutative justice is implicit since it dictates what is owed to each, rendering to every individual that which is owed equality and impartially (Pellegrino, 1995).

Every nurse is a moral agency who is influenced by intention, desire, choice, strength of will, and caring (Pellegrino, 1995). Judgments will be made

about whether a nurse's moral conduct is in accord with expected norms of society. Acts will also be judged upon if they produce good, harm, or more harm than good (Pellegrino, 2003). And finally the outcome will be the consequence of an act which will have moral force (Pellegrino, 1995).

Virtues, ethics, and morality are the general principles that form the basis for Nightingale's Pledge (Pellegrino, 1995). Nightingale's Pledge offers an outline for an ethical and moral practice that a nurse is obligated to uphold upon entering this helping profession. Nursing's ethical obligations have been revised in the American Nurses' Association's *Code of Ethics* (2001).

American Nurses' Association's Code of Ethics

Morality is still considered appropriate for guiding a nurse's practice today. The American Nurses Association's *Code of Ethics* makes explicit the primary goals and values of the profession (American Nurses Association (ANA), 2001). Ethics and morality is an integral part of the foundation of nursing and the ethical tradition of nursing is enduring and distinctive with values and obligations to those who are cared for by nurses (American Nurses Association, 2001). The nurse is obligated to practice with compassion and respect for the dignity, worth, and uniqueness of individuals in every relationship established in the practice of nursing (American Nurses Association, 2001). Nursing, as a profession, is responsible for shaping health care within our nation and affects the quality of that care. And each individual nurse has obligations to practice in a moral manner that follows these established codes.

Nurses learn to be moral agents and are professionally obligated to live by this *Code of Ethics*. Nurses train other nurses entering the professions by

example, by demonstrating what is accepted by society as moral and virtuous actions. Then learning continues by allowing novice nurses to learn by trial and error: allowing them to make choices, following through with actions, and then evaluating the consequences of the actions, taking care to note their intent in rendering a decision to act in a certain way and the circumstances involved.

Nurses care for patients in many ways. Individuals become patients when they acknowledge that they have a physical or psychological symptom they believe they need the help that a nursing professional can provide (Pellegrino, 1995). In order to proceed with their lives, patients seek out the healthcare professionals, such as nurses, to be helped, healed, or cared for (Pellegrino, 1995). The nursing professional then asks 'How may I help?' Implicit in this question is the promise that the nurse possesses the knowledge needed to help and intends to use this knowledge in the best interests of the patient (Pellegrino, 1995). And in helping a patient, a covenant of trust is established which imposes obligations on the professional nurse (Pellegrino, 1995). The act of healing itself includes acts that are therapeutic to 'help' this patient, entailing technically correct and morally good decisions and actions (Pellegrino, 1995).

Goals of Nursing

Nursing incorporates ethics in practice on a daily basis. Nursing is practiced in real settings with real patients, real possibilities, real constraints, and differing resources. The goals of nursing are to assist the sick and suffering patient, encourage health of a patient as well as a community, and work towards the betterment of society (Benner, 2001). Clinical discernment and healing

relationships cannot be reduced to rules and protocols but require personal judgments for a worthy end.

Nursing theory assists in explaining and predicting, it shapes questions and allows systemic observations of events and phenomenon (Benner, 2001).

Theorists try to identify the necessary and sufficient conditions for certain situations to occur (Benner, 2001). This allows theories to be created to predict how a nurse's action will affect an outcome in a particular situation. Expertise develops when nurses test and refine propositions, hypothesis, and principle-based expectations in actual situations (Benner, 2001). Expertise in complex decision making processes, such as nursing, makes the interpretation of clinical situations possible and the knowledge embedded is central to the advancement of nursing knowledge and practice (Benner, 2001).

According to Benner (2001), not all of the knowledge embedded in expert practice can be captured in theoretical propositions. However, the intentions, expectations, meanings, and outcomes of expert nursing practice can be described and aspects of clinical know-how can be captured. Benner believes nurses advance through stages as they advance their knowledge and develop their skills.

Benner's Conceptual Framework

Benner's theory uses the Dreyfus model as its framework and believes a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 2001). These different levels reflect changes in three general aspects of skill performance. First is a movement from reliance on abstract principles to incorporating concrete experiences into practice.

The second is a change in the learner's perception of a situation, from a collection of equally relevant bits to a compilation of parts that are relevant to the situation to create a whole picture. The third is a passage of detached observer to an involved performer where the individual no longer stands outside of a situation but is engaged in the situation.

As a nurse advances through the stages of professional development from novice toward expert, many experiences are encountered. Experience is not quantified by mere passage of time in nursing, it is developed through encounters with many actual situations (Benner, 2001). Not all nurses advance to the expert level because expert nurses have certain virtues and demonstrate certain characteristics of behavior, they are the epitome of a 'good nurse'. Theory offers explicit and formalized guides but clinical practice is always more complex and presents more realities than can be captured by theories. Theory guides practice and enables nurses to ask the right questions but experience offers refinements of theories so they can be applied in real concrete situations. Theories and research are generated from the practical world-that is the practices of experts in the field.

From assumptions and expectations in clinical practice, expert nurses discover questions for scientific testing and theory building (Benner, 2001). Attributes of good practice in the field of nursing often go unnoticed and undocumented, which could leave out an essential phase in theory development. A nurse who has a variety of experiences has a rich knowledge base in which to expand and interpret new situations. This multifaceted knowledge base with its concrete referents cannot be placed in abstract principles or explicit guidelines.

Experience and mastery transforms the practice of nursing into a science as well as an art.

Benner's Competencies and Virtues of Expert Nurses

Benner created a list of virtues describing the expert or good nurse. She conducted a study to determine the competencies that nurses exemplified in actual clinical practice utilizing a qualitative approach. She asked, what is a good nurse? Thirty-one competencies emerged and seven domains were created based of similarity of function and intent (Benner, 2001). The strength of her study comes from gathering information from the community of nurses who were in actual practice instead of having experts generate competencies from models or hypothetical situations.

A narrative inductive approach was utilized to provide a rich description of nursing practice (Benner, 2001). Seven domains of nursing practice were defined: the helping role, the teaching-coaching function, the diagnostic and patient-monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organizational and work-role competencies. Virtues of nursing also evolved: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Volbrecht, 2002). Benner emphasized this list of virtues was not exhaustive of the virtues of nursing and must be verified by a wider community of nursing and different specialties (see Table 1).

Table 1

Benner's Nursing Virtues

<i>Virtue</i>	<i>Definition</i>
Compassion	An empathetic understanding of challenges in health, sympathetic response, and a disposition to alleviate suffering or to comfort
Fidelity to trust	Honesty and promotion of patient well-being such that a patient can trust the nurse's benevolence
Moral Courage	Willingness to risk personally to protect the safety of a patient and promote patient well-being
Justice	Giving what is due to each person including respect and promotion of well-being; commitment to fair distribution of health care resources and costs to the community
Mediation	Disposition to facilitate cooperation and communication among nurses, patients, families, and other health care providers
Self-confidence	Respect for one's own professional abilities and knowledge
Resilience	Ability to recover from loss or stress; ability to see oneself not as a victim but as an advocate for one's patient, one's profession, and oneself
Practical reasoning	Ability to identify relevant moral considerations and to actively interpret particular situations and adapt
Integrity	Ability to integrate one's personal and professional life in such a way that the nurse is morally whole, consistent, and trustworthy

Studies of Moral Virtues

Armstrong, Parsons, and Barker (2000) conducted an inquiry into the moral virtues, specifically compassion in psychiatric nurses. The Delphi technique using rounds of postal questionnaires were used to elicit information on this complex topic. This type of study seeks to achieve consensus of opinions from respondents or to identify reasons for divergence. The Delphi technique stresses anonymity of respondents, the selection of 'experts' for participants, and the use of controlled iteration and feedback.

Eight debates emerged and developed throughout the study: the nature and role of moral virtues in psychiatric nursing, the meaning and importance of compassion in psychiatric nursing, the meaning of a 'good' mental health nurse, the meaning and importance of being empathetic towards clients, interpretations of 'ethical problems' and the distinctions, if any, between these and 'ethical dilemmas', definitions and interpretations of the moral concepts of 'patient's rights', nurses' moral duties, nurses' legal duties, and the four bioethical principles (Armstrong et al., 2000). The study focused upon and elaborated on the first two debates because they were prominent, philosophically interesting, and relevant to clinical practice (Armstrong et al., 2000).

Armstrong's study (2000) interpreted the moral virtues as being positive traits of character but differed from Aristotle and most contemporary virtue ethicists in denying that these can be learned. The virtues, especially compassion, but also benevolence, honesty, and empathy developed as an important pattern of interests by respondents. Nurses communicated using 'virtue' terms such as 'care', 'fair', 'honest', 'just', and 'compassion'. But the nurses in this study did not associate these terms as or being virtues (Armstrong, 2000).

Pang, Sawada, Konishi, Olsen, Yu, Chan, and Mayumi (2003) conducted a study to compare Chinese, American, and Japanese nurses' perceptions of ethical role responsibilities relevant to nursing practice. Publications on nursing ethics in the USA, China, and Japan revealed differences in nurses' moral concerns (Pang et al., 2003). Nursing ethics in China focused on moral education, the cultivation of desirable qualities in health workers, and fostered a sense of morality in various settings. American nurses focused on fostering the principles of autonomy and

beneficence. The moral concerns of Japanese nurses focused on information disclosure, use of technological advances, and end-of-life care. The purpose of the study was to examine whether nurses in other parts of the world would have similar views to those of Chinese nurses on their responsibilities in hospital practice and explore the ways which Chinese, American, and Japanese nurses perceive these responsibilities as their ethical responsibilities.

Nurses' responsibilities were categorized into three categories: principle-based, virtue-based, and care-based. The Chinese nurses were more virtue based in their responses of ethical responsibilities, American nurses were more principle based, and the Japanese nurses were more care based. This study was important in dialoguing among the nursing community in international arena.

Lutzen, Everton, and Nordin (1997) conducted a study to examine psychiatrists' responses to moral statements related to decision making. The Moral Sensitivity Questionnaire (MSQ) (Lutzen et al., 1997) was developed (Appendix B). The MSQ (Lutzen et al., 1997) presents 30 statements constructed from the following categories: interpersonal orientation, structuring moral meaning, benevolence, modifying autonomy, experiencing moral conflict, trust in medical knowledge, and principles of care. The respondents were asked their level of agreement or disagreement on a Likert-scale of 1 to 7. The analysis was based upon a sample of 734 psychiatrists from Sweden. The study showed that there were significant differences in the item and category levels: males experienced more conflict than females and agreed to a greater extent that medical knowledge was most important to deciding what is best for a patient ($p < 0.01$). Cronbach's

alpha coefficient of .64 was established and the data were analyzed using analysis of variance (ANOVA).

This study was replicated by Lutzen, Johansson, and Nordstrom (2000) to investigate the differences of nurses and physicians sensitivity to ethical dimensions of clinical practice in two settings: general medical and psychiatric. The sample consisted of 113 physicians working in general medical settings, 150 nurses working in general medical settings, 665 psychiatrists, and 145 nurses working in psychiatry. Significant differences were noted in respondents from general medical settings and those working in psychiatric settings. The former agreed with the assumptions in the categories of meaning and autonomy to a greater degree; and to a lesser degree did the former group agree with the categories of benevolence and conflict. There were also significant differences between nurses and physicians ($p < 0.001$), and between males and females ($p < 0.001$).

The findings of these two studies utilizing the MSQ (Lutzen et al., 1997) imply that nurses and physicians are sensitive to different aspects of patient care. They may also engage in critical moral reflection from a different basis, that is different ways of thinking about ethical dilemmas (Lutzen et al., 2000). This type of research leads to an understanding of the variations in opinions and attitudes related to ethical issues among healthcare practitioners.

The Multidimensional Ethics Scale (MES) is an eight item, three-subscale measure developed by Reidenbach and Robin (1990) to evaluate ethics in the business setting (Appendix C). This instrument has been utilized in multiple studies (at least 10 empirical studies of business ethics) and many critiques (21 published

studies) have been written about this instrument (Hyman, 1996). The MES (Reidenbach & Robin, 1990) presents scenarios of ethical dilemmas in the business setting and asked respondents to choose from a three factor solution. The relativism subscale used by the MES (Reidenbach & Robin, 1990) appeared to be the best predictor of the forecasted behavior of others (average $r=0.43$). This assisted in allowing employers to determine how ethical employee behaviors would be in future business dealings.

Many other researchers have created adaptations of this instrument for use in other settings. Some researchers ask respondents to rank their level of agreement or disagreement of a scenario on a Likert-scale of 1 to 7. McAlpine, Kristjanson, and Porocho (1997) used an adaptation of the MES (Reidenbach & Robin, 1990) and created an Ethical Reasoning Tool (ERT) to measure the ethical reasoning of nurses. The ERT is a qualitative instrument that asks open ended questions and allows the participant to answer in an unprompted manner to measure ethical thinking about practice dilemmas and identify areas of student learning/reasoning deficiency that could be addressed by educational interventions.

The development of the ERT underwent phases to establish the psychometric properties of this newly created instrument. The qualitative study presented a scenario, or a case study, to student nurses about an ethical dilemma in nursing practice and allowed them to identify the ethical dilemma, analyze the pertinent data, and provide a course of action. The students were not informed that they were participating in a study to prevent skewing the findings.

To establish the psychometric properties of the ERT instrument, a panel of three nurse educators and one philosopher reviewed it for clarity and content validity. Next inter-rater reliability and construct validity was evaluated. A pre-test and post-test was given to a population of 100 students. A random sample of 30 students was utilized in the analysis. The findings of the pre-test and post-test were coded and then combined to prevent determination if the test was the pre-test or the post-test. There was at least 75% agreement of levels of response of the raters. Construct validity was established using Wilcoxin matched pairs to test for changes in the pre-test and post-test responses. Statistically significant changes occurred in three categories: recognition of ethical issues ($p < 0.0009$), use of an ethical framework ($p < 0.0001$), and use of personal values to direct decision making ($p < 0.0009$). The ERT only asked a stem question and allowed the participant to answer in any fashion, making comparisons of responses difficult and establishing a predictive instrument impossible in this format. The ERT appears to demonstrate a promising method for measuring professional responses to ethical issues and was a stepping block to developing a quantitative instrument that is able to compare responses of one nurse to another.

Assessment of a Newly Created Psychometric Instrument

Any new instrument must undergo multiple methods of evaluation to develop validity and reliability. The tests must be systematic, address a need for objectivity in the testing process, and provide responses that are not assessing an individual on a pass or fail basis; that is, responses will group personality traits instead of seeking a right or wrong response. Psychometric testing is a systematic procedure for obtaining samples of behavior, relevant to cognitive or affective

functioning, and for scoring and evaluating those samples to compare to some type of standard (Urbina, 2004). Psychometric tools are designed to help in drawing inferences about individuals or groups; that is increasing self-knowledge and self-understanding.

A newly developed instrument must be shown to be valid to gather the information the researcher intends to discover and reliable to make sure the scores are trustworthy, and consistently report the data sought by the researcher (Urbina, 2004). Face validity can be accomplished by allowing a group of experts to review and critique the instrument. One way to assure reliability and validity of a new instrument is to establish concurrent validity; that is to compare the results of the new instrument with the results of an instrument that has established, documented reliability and validity. A pilot study helps further establish validity and allows the researcher to discover any potential problems that could occur before conducting the main study. Another way to establish reliability of a new instrument is to evaluate the instrument under test-retest scrutiny. When the instrument has undergone multiple tests to establish reliability and validity, it is ready to be utilized in a main study. Finally, the study should be replicated to further establish the validity and reliability to such an instrument.

A psychometric testing instrument assessing the traits or virtues of individuals, will likely measure if certain variables affect the behavior of these individuals. This will help lead to generating a hypothesis to draw inferences about an individual's behavior. The goal of this dissertation is to put the newly created Byrd's NEST instrument through multiple testing methods to ensure its validity and reliability to assess ethical sensitivity based on virtues as defined by Benner that

are important to nursing practice in order to lead to improved patient care and improved patient outcomes.

Summary

The discussion about the morality of human beings began with Plato's understanding of morality as being an integral part of one's character and the idea that society judges if one is moral by examining one's actions, circumstances surrounding one's actions, and the consequences resulting (Butts, 2003). He gave society the four cardinal virtues (wisdom, courage, temperance, and justice) and began the everlasting discussion of morality and virtue ethics.

Philosophers throughout the ages discussed the definition of morality and virtue, tried to decide if humans could be taught to be virtuous, and attempted to decide if people were obligated to be virtuous. Most agree that a moral or virtuous person is one who chooses to do good in any circumstance, for the sake of good (Pellegrino, 1995). Virtue is a trait orientated to ends and purposes, an excellence of reason not emotion, centered on practical judgment, and learned by practice (Pellegrino, 1995). The moral agent is expressed in terms of intention, desire, choice, strength of will, and caring (Pellegrino, 1995). Judgments will be made if conduct is in accord with expected norms of society and acts will also be judged upon the outcomes they produce (Pellegrino, 1995). In order to encourage better patient outcomes, the nursing profession has shown to value the virtues identified by Benner: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Volbrecht, 2002).

Armstrong's study (2000) interpreted the moral virtues as being positive traits of character but differed from Aristotle and most contemporary virtue ethicists

in denying that these can be learned. The virtues, especially compassion, but also benevolence, honesty, and empathy developed as an important pattern of interests by respondents. Nurses communicated using 'virtue' terms such as 'care', 'fair', 'honest', 'just', and 'compassion'. But the nurses in this study did not associate these terms as or being virtues (Armstrong, 2000). Pang, Sawada, Konishi, Olsen, Yu, Chan, and Mayumi (2003) compared Chinese, American, and Japanese nurses' perceptions of ethical role responsibilities relevant to nursing practice. Chinese nurses were more virtue based in their responses of ethical responsibilities, American nurses were more principle based, and the Japanese nurses were more care based. This study was important in dialoguing among the nursing community in international arena. These studies lay the groundwork for dialoguing within the nursing community and exploring ethics and virtues in nursing.

Morality in nursing is not easy to define, its characteristics are difficult to list, and what constitutes morality changes as society changes. There are many situations where there is no clear cut right and wrong, there have been no precedents set, and there is uncharted territory in which we enter. This area grows daily as the gray zone increases due to the leaps and bounds of discoveries and technologies in medicine and nursing. Nursing must be prepared to enter these discussions to improve patient care and enhance the environment to make it more conducive to providing ethically appropriate care.

Humans really do want to be moral, strive to be moral, and can be moral (Pellegrino, 2003). Nursing is a shining example of the belief that nurses should be moral which is advocated by its professional codes of ethics (ANA) and based upon the belief that a person can be virtuous and work for the good of others. It is

necessary that nursing explore the virtues of expert nurses and develop instruments to assess the ethical decision-making processes of these expert nurses in order to advance the profession of nursing and be able to articulate the values of nursing to those outside of nursing.

CHAPTER III

METHODOLOGY

The purpose of this dissertation was to develop and analyze the psychometric properties of the Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST) instrument, which was originated by this researcher. The Byrd's NEST instrument analyzed ethical sensitivity of nurses by examining their choices of actions in ethical dilemmas in practice based on nursing virtues as defined by Benner, Tanner, and Chesla (1996): compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Volbrecht, 2002). Virtues are considered to be the nurse's degree of moral or ethical expertise.

The primary question was as follows: What are the psychometric properties of the proposed instrument, Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST)? Second, the investigator determined if there were relationships between the ethical sensitivity scores and a nurse's educational level in nursing, years of experience as registered nurse, specialization in fields of nursing, and the work environment of the nurse. The development and psychometric testing of an instrument to analyze the ethical sensitivity of nurses increases the depth of knowledge in psychometric testing in nursing and nursing ethics, and potentially affect the development of methods to encourage and enhance nursing practice leading to improved patient outcomes.

Research Design and Approach

The research design is methodological and consisted of examining psychometric properties of this newly created instrument. Multiple methods were

used to evaluate the psychometric properties of the Byrd's NEST instrument. Data was examined for relationships between the variables.

Methodology

The following will present the process of this instrument's development.

1. Review literature related to virtue ethics, nursing virtues, expert nursing, and ethical decision making in nursing as related to literature.
2. Identify the virtues of ethical decision making in nursing practice from literature: compassion, fidelity to trust, moral courage, justice, mediation, self-confidence, resilience, practical reasoning, and integrity.
3. Develop an instrument that establishes the level of nurses' ethical sensitivity - *Byrd's Nurse's Ethical Sensitivity Test* (Byrd's NEST). Ten scenarios are presented that are ethical dilemmas in nursing practice followed by three multiple choice responses to allow participants to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts. The different virtues in nursing were presented in each scenario.
4. Preliminary study: Evaluate the preliminary version of the Byrd's NEST – also known as Byrd's NEST (P-1) (Appendix D)– (10 scenarios presenting ethical dilemmas in nursing practice that were created by the present researcher], along with 10 items adapted from the MSQ (Lutzen et al., 1997) (Appendix E) and five scenarios adapted from the MES (Reidenbach & Robin, 1990) (Appendix F) for item construction, face validity, content validity, and clarity (or readability of questions) based on the responses of two panels of experts.

5. Establish scoring of the Byrd's NEST and the five scenarios adapted from the MES (Reidenbach & Robin, 1990); establish inter-rater reliability.
6. Make refinements to Byrd's NEST (P-1), the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) and create Byrd's NEST (P-2) (Appendix G).
7. Small pilot study: Evaluate the Byrd's NEST (P-2) along with the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) for item construction, face validity, content validity, and clarity (or readability of questions) based on the responses of a convenience sample of 20 registered nurses with two administrations of the instrument approximately two weeks apart (test-retest reliability-stability).
8. Make refinements to Byrd's NEST (P-2), the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) and create Byrd's NEST (P-3) (Appendix H).
9. Large Pilot Study: Send survey to 500 registered nurses random sample: Evaluate the Byrd's NEST (P-3) along with the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) with surveys mailed to 500 registered nurses from a random sample of members of the American Nurses Association (ANA) through a one-time mail-out administration.
10. Establish concurrent validity of the Byrd's NEST with the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) and determine nurses' degree of ethical sensitivity based on the virtues of nurses defined by Benner (1996) as related to educational

level in nursing, years of experience in nursing, specialization in nursing, and work setting.

Psychometric Analysis of the Byrd's NEST

For psychometric testing of the Byrd's NEST instrument, the preliminary study, the small pilot study, and the large pilot study began with an introductory letter from the researcher (Appendix I) and the Demographic Data Sheet (Appendix J) followed by 10 items from the MSQ (Lutzen et al., 1997) (Appendix E), the Byrd's NEST (Appendix A), and five scenarios adapted from the MES (Reidenbach & Robin, 1990) (Appendix F).

Establishing Concurrent Validity with the Byrd's NEST

The first section consisted of 10 items from the Moral Sensitivity Questionnaire (MSQ) (Lutzen et al., 1997) (Appendix E); statements were presented that described characteristics a nurse would demonstrate in certain situations, the nurse was asked to rate their degree of agreement to disagreement on a Likert-type scale of 1 to 7. The scores of the MSQ were correlated with the ethical sensitivity scores to establish concurrent validity.

The second section consisted of the Byrd's NEST instrument, 10 scenarios that present ethical dilemmas in nursing based on the virtues of nursing as defined by Benner (1996), along with five scenarios adapted from the Multidimensional Ethics Scale (MES) (Reidenbach & Robin, 1990) (Appendix F) integrated throughout the Byrd's NEST.

Origination of MES Scenarios

The scenarios, adapted from the MES (Reidenbach & Robin, 1990), were included in Byrd's NEST P-1 through P-3 (Appendix J); question three was

adapted from MES scenario about the Media Buyer, Nancy Brown, accepting gifts from distributors; question six-was adapted from MES scenario about stealing computer software, Meg Dempsey; question nine-was adapted from MES scenario about product shortage, C. Kemp giving a Christmas toy (hot item in short supply) to family members before those on waiting list; question 12-was adapted from MES scenario about inappropriate medical waste disposal; and question 15-was adapted from MES scenario about control settings being changed without permission, Laura Ekins. The scenarios adapted from the MES (Reidenbach & Robin, 1990) had similar structure and language as the scenarios created for the Byrd's NEST so that they cannot be distinguished as originating from a different source. An ethical dilemma in nursing is posed in the scenarios followed by 3 multiple choice responses to allow the participant to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts.

Scoring of Byrd's NEST

Byrd's NEST instrument consists of 10 scenarios that present ethical dilemmas in nursing practice based on the virtues of nursing as defined by Benner (1996) (Appendix K). An ethical dilemma in nursing was posed in the scenarios followed by three multiple choice responses to allow the participant to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts. Inter-rater reliability was established at 0.76, an acceptable coefficient for reliability. For each response low

degree of ethical sensitivity was equivalent to a score of 1, medium degree of ethical sensitivity was equivalent to a score of 2, and high degree of ethical sensitivity was equivalent to a score of 3. The total scores possible were 10 to 30. Table 2 reflects Byrd's NEST Individual Item Scoring.

Table 2

Byrd's NEST Individual Item Scoring

Degree of ethical sensitivity	Item Score
Low	1
Medium	2
High	3

Since there was a variance of 21 points, the range for each degree of ethical sensitivity took the total scores possible and divided by 3 creating a possible range for each degree of ethical sensitivity of 7 points. For the total score, low degree of ethical sensitivity was equivalent to a total score of 10 to 16, medium degree of ethical sensitivity was equivalent to a total score of 17 to 23, and high degree of ethical sensitivity was equivalent to a total score of 24 to 30. Table 3 reflects Byrd's NEST Total Scoring.

Table 3

Byrd's NEST Total Scoring

Degree of ethical sensitivity	Total Score
<hr/>	
Low	10-16
Medium	17-23
High	24-30

Concurrent Validity Scoring

MSQ (Lutzen et al., 1997): 10 items were adapted and used (Appendix E). The scoring was based on a Likert-type scale of 1 to 7, with 1 being completely disagree and 7 being completely agree with a possible total score of 10 to 70. Statements 2, 5, 6, 7, 9 are reverse scored. Low MSQ score was equivalent to a score of 10 to 30, a medium MSQ score was equivalent to a score of 31 to 50, and a high MSQ score was equivalent to a score of 51 to 70. Table 4 reflects MSQ total scoring for the small pilot study.

Some of the respondents in the smaller pilot study found the MSQ items confusing. For the large pilot study, in an attempt to create clearer instructions for the use of the 10 items adapted from the MSQ instrument, the Likert-type-type scale of 1 to 7 was removed and replaced with a Likert-type scale of 1 to 5 but with wording.

Table 4

MSQ Total Scoring for Small Pilot Study

Degree of ethical sensitivity	Total Score
Low	10-30
Medium	31-50
High	51-70

The participants were asked to circle the best response to rank their level of agreement or disagreement to the statements regarding their nursing practice. Selections were completely agree, somewhat agree, agree, somewhat disagree, and completely disagree. Table 5 presents the revised total scoring of the MSQ items for the large pilot study.

Table 5

MSQ Total Scoring-Revised for Large Pilot Study

Degree of ethical sensitivity	Total Score
Low	10-22
Medium	23-36
High	37-50

MES (Reidenbach & Robin, 1990): five scenarios adapted from the MES (Reidenbach & Robin, 1990) (Appendix F) were used and integrated throughout

the Byrd's NEST. An ethical dilemma in nursing was posed in the scenarios followed by three multiple choice responses to allow the participant to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts in the preliminary study. For each response, low degree of ethical sensitivity was equivalent to a MES score of 1, medium degree of ethical sensitivity was equivalent to a MES score of 2, and high degree of ethical sensitivity was equivalent to a MES score of 3. The total MES scores possible were 5 to 15. Since there was a variance of 11 points, the range for each degree of ethical sensitivity took the total scores possible and divided by 3 creating a possible range for each degree of ethical sensitivity of approximately 4 points – the medium range was given the 3 point range. Total MES score of 5 to 8 was equivalent to low ethical sensitivity, 9 to 11 was equivalent to medium ethical sensitivity, and 12 to 15 was equivalent to high ethical sensitivity. Table 6 presents the MES total scoring.

Table 6

MES Total Scoring

Degree of ethical sensitivity	Total Score
Low	5-7
Medium	9-11
High	12-15

Experts' scoring of the Byrd's NEST and MES scenarios

Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by a panel of 3 nursing experts. Inter-rater reliability was established at 0.76. The following chart identifies the responses according to high, medium, and low degrees of ethical sensitivity. Byrd's NEST questions, as well as the five questions adapted from the Multidimensional Ethics Survey (Reidenbach & Robin, 1990), were scored by the panel of three expert nurses (Scoring of Byrd's NEST-Appendix L).

Virtues Within Questions

The different virtues in nursing as defined by Benner (1996) are presented in the scenarios: compassion, fidelity to trust, moral courage, justice, mediation, self-confidence, resilience, practical reasoning, and integrity. Some scenarios examined multiple virtues but the main virtue being examined is noted (Virtues in questions-Appendix M).

Instruments and Materials

Byrd's Nurse's Ethical Sensitivity Test (Byrd's NEST) Instrument Construction

1. An introductory letter was created to explain the significance of the study, ask for participation and seek consent to participate which will be implied by returning a completed questionnaire (Appendix I).
2. A demographic data section (Appendix J)
3. Moral Sensitivity Questionnaire ([MSQ]; Lutzen et al., 1997): 10 Items from the MSQ (Lutzen et al., 1997) (Appendix E) presented statements about characteristics nurses demonstrate in ethical situations and asked the nurse to rate their degree of agreement to disagreement on a Likert-type scale. This established

reliability by comparison of the scores of the MSQ (Lutzen et al., 1997), a previously documented instrument, with the scores of the newly created instrument, the Byrd's NEST.

4. Byrd's NEST -10 scenarios were created by the present researcher, developed from an extensive search of nursing literature concerning ethical dilemmas in nursing and from the researchers own experience in nursing over 20 years. The scenarios presented are ethical dilemmas in nursing practice followed by three multiple choice responses to allow participants to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts. The different virtues in nursing as defined by Benner (compassion, fidelity to trust, moral courage, justice, mediation, self-confidence, resilience, practical reasoning, and integrity) are presented in the scenarios. The Byrd's NEST underwent refinements as input was received from the different testing procedures (Preliminary version or Byrd's NEST P-1 – Appendix D; second version or Byrd's NEST P-2 – Appendix G; third version or Byrd's NEST P-3 – Appendix H).

5. Multidimensional Ethics Scale ([MES]; Reidenbach & Robin, 1990): five scenarios were adapted from the MES (Reidenbach & Robin, 1990) (Appendix F) and integrated throughout the Byrd's NEST. The scenarios presented were ethical dilemmas in nursing practice followed by three multiple choice responses to allow participants to choose what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree of ethical sensitivity as determined by the panel of nursing experts. These

scenarios had similar structure and wording to the scenarios of Byrd's NEST and were scattered throughout the survey so they could not be distinguished as originating from a different source. This was done to establish concurrent validity of the Byrd's NEST.

Steps of Byrd's NEST Instrument Development

A search for instruments to assess ethical sensitivity in nurses was conducted. This search did not discover any instruments available to analyze ethical sensitivity in nurses. No instruments were found to assess virtues in the decision making process of nurses.

However, an instrument that assessed similar constructs was the Moral Sensitivity Questionnaire (MSQ) developed by Lutzen, Everton, and Nordin (1997) (Appendix B). Lutzen was emailed and permission was granted for use of the MSQ as concurrent validity in this dissertation (Appendix N). Another instrument used to assess business ethics was the Multidimensional Ethics Scale (MES) (Appendix C) developed by Reidenbach and Robin (1990). Reidenbach was emailed and permission granted for use of the MES as concurrent validity in this dissertation (Appendix O).

The Byrd's *Nurse's Ethical Sensitivity Test* (NEST) was developed by this researcher and consists of 10 scenarios presenting ethical dilemmas in nursing practice. Ten other items were selected and adapted from the MSQ (Lutzen et al., 1997) and five other scenarios were selected and adapted from the MES (Reidenbach & Robin, 1990) to create the instrument for this dissertation. The preliminary version created was the Byrd's NEST (P-1) (Appendix D) which was reviewed by a statistician who is expert in test development, a registered nurse

who is expert in instrument development, and a registered nurse who is expert in nursing ethics for preliminary analyses of (a) item construction, (b) face validity, (c) clarity and reliability (to reduce error from misunderstanding), (d) concurrent validity, and (e) psychometric properties. The Byrd's NEST (P-1) was also presented to three expert nurses for analyses of these same items and scoring of the responses for degree of ethical sensitivity on a scale of low, medium, and high. Refinements were made of Byrd's NEST (P-1), as well as refinements of the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990), resulting in creation of Byrd's NEST (P-2) (Appendix G).

Next, the Byrd's NEST (P-2) instrument was administered to 20 registered nurses and then repeated to the same nurses approximately two weeks later. The participants in this convenience sample of 20 nurses were given a postcard to return with their survey to obtain addresses to send the second administration of the Byrd's NEST. The postcard was to be returned in the envelope along with the survey. The postcards and surveys were separated after both surveys were returned, analysis of data completed, and then no correlation was made between the survey and the postcard. Confidentiality was maintained. An incentive was offered to those nurses who participate in both surveys, a chance to be entered in a drawing for a \$100.00 gift certificate to Wal-Mart. This pilot study established reliability by surveying a sample of nurses with the same instrument twice and established survey item stability. Refinements were made of Byrd's NEST (P-2) as well as the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five

scenarios adapted from the MES (Reidenbach & Robin, 1990), resulting in creation of Byrd's NEST (P-3) (Appendix H).

The final step of testing for this instrument development, a large pilot study, utilized the Byrd's NEST (P-3) (Appendix H) instrument along with the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) to survey a larger sample that was sent to 500 nurses to document concurrent validity of the Byrd's NEST with the items from the MSQ (Lutzen et al., 1997) and the scenarios adapted from the MES (Reidenbach & Robin, 1990) and to examine for correlations between the ethical sensitivity scores and educational level in nursing, years of experience as registered nurses, specialization in fields of nursing, and the work environment of the nurse. This was a one time mail-out survey to a random sample of registered nurses who are members of the American Nurses Association (ANA). The nurses had varying educational degrees, with a variety of years of experience, who work in a variety of specialties, and in a variety of settings. The registered nurse must have been prepared by an accredited school of nursing, taken and passed the state registered nurse test, and was practicing as a registered nurse. This sample of nurses is representative of the nursing community.

All potential participants were sent a postcard to return with their survey to be entered in a drawing for a \$100.00 gift certificate to Wal-Mart, as an incentive to participate in the survey. The postcards and surveys were separated upon receipt by the researcher and no correlation was made between the survey and the postcard. The results were anonymous and presented as a compilation of the findings. The results are being kept by the researcher but have no identifying data

of individual surveys. The participants had the opportunity to receive a report of the findings upon request.

Setting and Sample

The preliminary testing for the Byrd's NEST (P-1) (Appendix D) instrument allowed a panel of three experts: the statistician, the registered nurses expert in instrument development, and the registered nurse expert in nursing ethics (nursing ethicist), to complete the instrument in a setting of their choice, at their convenience, and to return the instrument within two weeks of receiving the instrument. The next panel of three expert registered nurses was asked to complete the Byrd's NEST (P-1) in a setting of their choice, at their convenience, and to return the completed instrument within two weeks. The pilot sample of 20 registered nurses was asked to complete Byrd's NEST (P-2) (Appendix G) in a setting of their choice, at their convenience within one week of receiving the instrument.

The large pilot study, the survey that was sent to 500 registered nurses was administered the Byrd's NEST (P-3) instrument in a one-time mail-out survey to the home addresses of the sample. The sample list was purchased from the American Nurses Association (ANA) whose membership consists of nurses of varying educational degrees, with varying years of experience, working in various setting across the United States. The participants were asked to complete the Byrd's NEST instrument in a setting of their choice, at their convenience, and if they wished to participate in this study, to return the completed survey within 2 weeks in the stamped and addressed return envelope.

Human Subjects Protection

The University of Southern Mississippi's Human Subjects Protection Review Committee (HSPRC) reviewed and approved this research proposal (Approval letter – Appendix P). The following items were addressed in order to prevent harm to any participants in any aspect of this study. The survey was to be answered anonymously and with no identifying data included on the survey. There were no experimental treatments included in this study, no foreseeable harm could occur from this survey, and the information was released as a compilation of the findings. Confidentiality and anonymity was maintained and assured to the participants. Informed consent was explained in the letter explaining the survey and asking for participation. It was stated that consent is assumed by completion and return of the survey. Participation was voluntary and participants could withdraw or choose not to participate by not returning the surveys without fear of retaliation by the researcher. All potential participants were able to return a postcard along with their survey to be entered into a drawing for a \$100.00 gift certificate to Wal-Mart. The postcards and the survey were separated upon receipt by the researcher and no correlation was made between the survey and the participant. The researcher will keep all data and questionnaires for five years in a locked file cabinet and then destroy it.

Data Analysis

The Byrd's NEST was analyzed by multiple methods of psychometric testing. Initially, the preliminary version, Byrd's NEST (P-1) (Appendix D) instrument, was presented to a panel of experts in psychometric testing and nursing ethics content. This group consisted of one expert statistician, one

doctorally prepared registered nurse who has expertise in instrument development, and one doctorally prepared registered nurse who has expertise in nursing ethics and considered an expert in the nursing field. Then a panel of three additional expert nurses was asked to comment on the instrument, Byrd's NEST (P-1). Both groups evaluated this version for (a) item construction, (b) face validity, (c) content validity, (d) clarity and reliability (to reduce error from misunderstanding), (e) concurrent validity, and (f) psychometric properties; the panel of three expert nurses established scoring of the responses to the Byrd's NEST and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) on a scale of low - 1, medium - 2, and high - 3; inter-rater reliability was established; revisions were made accordingly resulting in creation of Byrd's NEST (P-2) (Appendix G). Total possible scores of the Byrd's NEST are on a range of 10 to 30, with total ethical sensitivity score of 10 to 16 was equivalent to low ethical sensitivity, 17 to 23 was equivalent to medium ethical sensitivity, and 24 to 30 was equivalent to high ethical sensitivity.

A small pilot study was then conducted with a convenience sample (N=20) who complete the Byrd's NEST (P-2) instrument at two different times, approximately two weeks apart so that the researcher can document test-retest reliability (these 20 nurses did not include any of the expert nurses used in the preliminary panels). Correlations were made of these findings. Concurrent validity was assessed by comparisons of the items from the MSQ (Lutzen et al., 1997) to the 10 scenarios the Byrd's NEST (P-2) and of the five scenarios adapted from the MES (Reidenbach & Robin, 1990) to the 10 scenarios in the Byrd's NEST (P-2). Refinements of the Byrd's NEST (P-2), the 10 items adapted from the MSQ

(Lutzen et al., 1997), and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) were made, which resulted in creation of Byrd's NEST (P-3) (Appendix H).

Finally, the large pilot study, the Byrd's NEST P-3 questionnaire was sent to a larger sample of 500 registered nurses: the 10 scenarios developed for the Byrd's NEST along with the 10 items adapted from the MSQ (Lutzen et al., 1997) and the five scenarios adapted from the MES (Reidenbach & Robin, 1990) to analyze the findings for concurrent validity and to examine any correlations between ethical sensitivity scores and educational level in nursing, years of experience as registered nurses, specialization in fields of nursing, and the work environment of the nurse was used to determine if these variables affect one's degree of virtues. The participants of the large pilot study who completed and returned the survey were 115 nurses. Their data were analyzed using the MANOVA. This method allowed examination of information analyzing data individually and in combination for varying groups of nurses. This method also allowed weighting of the variables that were examined and maximized the discrimination among groups of nurses (Nunnally & Bernstein, 1994; Urbina, 2004).

CHAPTER IV

ANALYSIS OF DATA

The primary question for this research was as follows: What are the psychometric properties of the instrument: Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST)? In this chapter, there is a presentation on a review of the steps taken to develop, revise, and evaluate the development of the newly developed instrument Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST). The psychometric properties of this instrument also are presented.

Initially a review of literature related to virtue ethics, nursing virtues, expert nursing, and ethical decision making in nursing was performed. The virtues of ethical decision making in nursing practice were identified from literature and based on Benner's theory of skill acquisition—novice to expert—to include compassion, fidelity to trust, moral courage, justice, mediation, self-confidence, resilience, practical reasoning, and integrity. This information, along with the fact that there were no instruments measuring ethical sensitivity in nursing practice, led the researcher to create an instrument to investigate the level of nurses' ethical sensitivity titled Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST).

From the review of literature, review of ethical dilemmas in nursing practice, and the researcher's 20 plus years of nursing experience, the researcher created 10 scenarios that are reflective of ethical dilemmas in nursing practice followed by three multiple choice responses which allowed participants to choose what course of action they would pursue in the dilemma. Each response or choice of action was selected and the scoring was scored on a scale of a high, medium, or low degree of ethical sensitivity. The different virtues in nursing are presented in the scenarios.

Preliminary Study (P-1)

A preliminary study was conducted. Two panels of experts evaluated the preliminary version of the Byrd's *Nurse's Ethical Sensitivity Test*, which is also known as Byrd's NEST (P-1) (Appendix D). This P-1 version consisted of 10 ethical dilemma scenarios that were created by the researcher, along with 10 items adapted from the Moral Sensitivity Questionnaire ([MSQ] (Appendix E); Lutzen et al., 1997) and five scenarios adapted from the Multidimensional Ethics Scale [MES] (Reidenbach & Robin, 1990) (Appendix F) for item construction, face validity, content validity, and clarity or readability.

The first panel was a panel of experts: one nurse expert in test development, one nurse expert in ethical content, and one expert statistician. There were several revisions as a result of the experts' input. Minor wording changes were made to some of the Byrd's NEST scenarios to decrease responder bias. Changes were also made to one of the measures used for concurrent validity (one of the five MES questions) to make wording similar to the scenarios created by this researcher for the Byrd's NEST instrument so that it could not be distinguished as arising from another source. The demographic data section was revised to remove extraneous information.

The second panel of experts consisting of three nursing experts examined the instrument for the same information and also scored the Byrd's NEST (P-1) and five scenarios adapted from the MES (Reidenbach & Robin, 1990). The responses were scored as a high, medium, or low degree of ethical sensitivity. Initially, inter-rater reliability was initially established at .67. Initially, there was disagreement for scoring of Byrd's NEST scenario 1, 3, and 4, and for MES

scenario 1. These scenarios were examined and wording changed. These scenarios were resubmitted to the panel of nursing experts for re-scoring, which improved congruence of scoring of the degree of ethical sensitivity. After these revisions, inter-rater reliability was established at .76. Byrd's NEST P-2 was the instrument developed from the recommendations of these two panels of experts after all revisions were made. The instrument consisted of 10 ethical dilemma scenarios that were created by the researcher, along with 10 items adapted from the MSQ (Lutzen et al., 1997) and five scenarios adapted from the MES (Reidenbach & Robin, 1990) (see Appendix G for Byrd's NEST P-2).

Small Pilot Study (P-2)

A small pilot study was conducted using a convenience and voluntary sample of 20 nurses, who were obtained from attendees at the Mississippi Nurses Association's (MNA) Convention 2005 in Philadelphia, Mississippi, in November 2005. The participants were drawn from a pool of voluntary candidates and their name and address were obtained. In January 2006, 20 nurses were sent the Byrd's NEST P-2 and asked to complete the instrument, then to return it in the self-addressed, stamped envelope within one week of receipt. For documenting stability, a second identical questionnaire was sent to the same 20 nurses to be completed and returned within 1 week of receipt. The instrument was returned in a self-addressed, stamped envelope and results were examined for test-re-test reliability (stability).

Demographic Data of the Small Pilot Study (P-2)

Educational degrees, specialty certification, years of experience as a nurse, and work setting were items examined to see if there was a correlation between

each of these variables and the ethical sensitivity scores. In Table 7, the compiled sample characteristics-demographic data-are presented. The average years as a registered nurse were a mean of 15.5 years with a standard deviation of 11.3 years. The average years in their present work setting were a mean of 11.8 years with a standard deviation of 11.5 years.

Findings of the Small Pilot Study (N=18)

The MSQ showed correlation with the Byrd's NEST items at a level of 0.516 ($p < .05$). The MES items and the Byrd's NEST items did not reveal a statistically significant correlation nor did the MSQ and the MES items. Table 8 represents the correlations of the small pilot study (N=18).

Review of the Findings of the Small Pilot Study (P-2)

Test/retest reliability

The findings of the small pilot study were examined. The scoring of the completed initial mail-out questionnaires and the second mail-out questionnaires were compared. There was not adequate reliability between the test and repeat testing (retest) of the test items. Table 9 presents the test/retest reliability (stability) comparing 15 initial test results to 7 retest results.

Internal consistency reliability

The MSQ items did not reveal internal reliability within itself, so the researcher attempted to clarify the response scale by changing the number scale from 1 to 7 level of agreement to disagreement to the statements to wording of completely agree, somewhat agree, agree, somewhat disagree, completely disagree. A question was added to the demographic section about ethics education in the nursing program of study. The returned instruments from the pilot

study were also examined for constructive criticism by the respondents who wrote recommendations.

Table 7

Demographic Data of Small Pilot Study Participants with Byrd's NEST P-2 (N=18)

Descriptive Variable	Frequency	Percentile
<i>Highest Educational Degree Obtained in Nursing (N=18)</i>		
Degree		
Diploma in Nursing	0	--
Associate Degree in Nursing (ADN)	2	11.1%
Baccalaureate Degree in Nursing (BSN)	4	22.2%
Master's Degree in Nursing (MSN)	11	61.1%
Doctor of Philosophy in Nursing (PhD) or other Doctorate	1	5.5%
<i>Specialty Certification Obtained</i>		
Yes	4	22.3%
No	14	77.7%
<i>Work Setting</i>		
Hospital	9	50.0%
Community/Outpatient	3	16.7%
Education	4	22.2%
Other	2	11.1%
<i>Race</i>		
Caucasian	14	77.8%
African American	4	22.2%
Hispanic	0	--
Other	0	--
<i>Gender</i>		
Female	17	94.4%
Male	1	5.6%

Table 8

Small pilot study: Correlations of MES, Byrd's NEST, and MSQ (N=18)

	MES	NEST	MSQ
MES			
Pearson Correlation		.191	.137
Sig. (2-tailed)		.448	.587
NEST			
Pearson Correlation	.191		.516(*)
Sig. (2-tailed)	.448		.029
MSQ			
Pearson Correlation	.137	.516(*)	
Sig. (2-tailed)	.587	.029	

* $p < 0.05$ level (2-tailed).

Table 9

Test/Retest Reliability (Stability)-Small Pilot Study (N=22:15 test / 7 retest)

		MES	NEST	MSQ
Test/retest	Pearson Correlation	.361	.176	.159
	Sig. (2-tailed)	.098	.434	.479

Internal consistency reliability

The MSQ items did not reveal internal reliability within itself, so the researcher attempted to clarify the response scale by changing the number scale from 1 to 7 level of agreement to disagreement to the statements to wording of completely agree, somewhat agree, agree, somewhat disagree, completely disagree. A question was added to the demographic section about ethics

education in the nursing program of study. The returned instruments from the pilot study were also examined for constructive criticism by the respondents who wrote recommendations.

Changes Made to Byrd's NEST (P-2)

The results of the small pilot study were examined for concurrent validity between the 10 ethical dilemma scenarios that was created as the Byrd's NEST, the 10 items adapted from the MSQ (Lutzen et al., 1997), and five scenarios adapted from the MES (Reidenbach & Robin, 1990) included in the P-2 form. There were some problems noted in the scoring. Of the participants that returned the instruments, 69% fit the definition of expert nurses with a master's degree or doctoral degree in nursing and greater than 10 years of nursing experience. The manner in which these expert nurses responded to certain items of the instrument caused this researcher to re-examine these items and their scoring Table 10 presents the rationales for questions revisions in the Byrd's NEST P-2.

Byrd's NEST P-3 (Appendix H) was the instrument that was developed from the recommendations once all revisions were made. The instrument consists of the 10 scenarios presenting ethical dilemmas in nursing practice created by this researcher, along with 10 items adapted from the MSQ (Lutzen et al., 1997) and five items adapted from the MES (Reidenbach & Robin, 1990) but with revisions.

Large Pilot Study of 500 Nurses (P-3)

In February 2006 a mail-out of the Byrd's NEST P-3 was sent to a large pilot sample of 500 nurses. The sample obtained from the American Nurses Association's (ANA) membership list. The sample was a randomized list from the membership and was purchased by the researcher for use in this study. Each

nurse was sent the Byrd's NEST P-3 (Appendix H) along with a self-addressed stamped envelope to return the survey and a card to be entered in a drawing for a \$100 gift certificate to Wal-Mart. The nurses were asked to return the instrument within two weeks of receipt of the survey.

Table 10

Questions revised from Byrd's NEST P-2

	Rationale
Question revisions: # 1, 2, 4, 5, 6, 11, 13, 15	Wording revised to make similar throughout the instrument.
Scoring revisions: #2	Scoring changed due to the feasibility of the nurse's ability to carry out the action. The nurse must be able to carry out the ethical action even when constrained by hospital policy.
Scoring revisions: #7	Outcome added to response 'C'. Response choice biased by the outcome being offered in responses 'A' and 'B', but not in response 'C'.
Scoring revisions: #10	Outcome was offered in response 'A' could bias the choice.

Demographic Data of Large Pilot Study (P-3)

Of the 500 surveys that were mailed out, 29 were returned due to wrong address, and 115 surveys were returned completed. Total years in nursing practice ranged from 1.5 years to 52 years, with a mean 24.2 years and a standard deviation of 11.5 years. The average years of experience was quite high and this finding could mean that the nurses returning this survey were expert nurses and their interest in assisting with efforts to advance the field of research in nursing

reflects their interest in furthering the professionalism of nursing practice. The average years in practice as a registered nurse were 24 years with a standard deviation of 11.5. The average years in their present work setting was 13.3 with a standard deviation of 9.4 years. Table 11 presents the demographic data, or characteristics, of the large pilot study.

A question was asked about ethics education in the nurse's program and Table 12 reflects these data. Only 11.3% did not have ethics education included in their nursing programs, which means there is a vested interest in the topic of nursing ethics by nurse educators and nursing schools. This also means that ethics is valued and efforts to advance research surrounding ethics would be of great interest to those who educate nursing students.

Change in Wording of MSQ Items & Error in Scale

To clarify the instructions for the use of the 10 items adapted from the MSQ instrument, the Likert-type scale of 1 to 7 was removed and replaced with a Likert-type scale of 1 to 5 but with wording. The participants were asked to circle the best response to rank their level of agreement or disagreement to the statements regarding their nursing practice. Selections were completely agree, somewhat agree, agree, somewhat disagree, and completely disagree. An error was made and the actual statements sent out in the instrument read: completely agree, somewhat agree, agree, somewhat agree, and completely agree. The word 'disagree' was left out and may have caused some confusion in the participants' responses. One respondent called the Institutional Review Board at USM to notify the researcher of the error. The researcher made multiple attempts to contact this

participant but was not successful. The researcher left a message to please note this on her survey and return it.

Table 11

Demographic Data of Large Pilot Study with Byrd's NEST P-3 (N=115)

	Frequency	Percentile
Highest educational degree obtained in nursing		
Diploma in Nursing	5	4.3%
Associate Degree in Nursing (ADN)	7	6.1%
Baccalaureate Degree in Nursing (BSN)	39	33.9%
Master's Degree in Nursing (MSN)	51	44.3%
Doctor of Philosophy in Nursing (PhD) or Doctorate	13	11.3%
Specialty certification obtained		
Yes	87	76.3%
No	27	23.7%
Work setting		
Hospital	76	66.1%
Community/Outpatient	11	9.6%
Education	16	13.9%
Other	12	10.5%
Race		
Caucasian	99	86.1%
African American	7	6.1%
Hispanic	6	5.2%
Other	3	2.6%
Gender		
Female	108	93.9%
Male	6	5.2%

Table 12

Ethics Education in the Nurse's Program (N=115)

	Frequency	Percentile
Ethics education was integrated in my nursing program that significantly affected my education	37	32.2%
Ethics education was integrated in my nursing program but was not emphasized	39	33.9%
Ethics education was a separate course taught in my nursing program	22	19.1%
Ethics education was not included in my nursing program	13	11.3%

Many of the respondents also noted the error in the scale for the MSQ items and wrote in the missing *dis* on agreement in the places where disagreement should have been so that the scale was corrected. For any instrument returned without these items corrected or without these items answered, the MSQ section was not included for analysis. However, the other responses were included in the data set.

Findings of the Larger Pilot Study (P-3)

There were 500 surveys sent out, 29 were returned for wrong address, and 115 surveys were returned for inclusion in these findings-115 out of 471 were returned, giving a 24% return rate. Of the 115 returned, 107 were fully completed and included in the data for analysis. Of these questionnaires completed, all participants completed the demographic section and only 9 participants did not correct the MSQ scale or did not respond to this section. All participants responded

to the section with the MES items and the Byrd's NEST items. Some respondents had concerns about some of the responses and did not complete certain items in the MES section of the Byrd's NEST P-3. Table 13 presents data concerning concurrent validity of the MSQ items, the MES items, and the Byrd's NEST items which did not reveal a statistically significant correlation in ethical sensitivity scores within the data set.

Table 13

Large pilot study: Pearson r Correlations between the Byrd's NEST Items, MSQ items, and MES items (N=107)

		MSQ	NEST	MES
MSQ	Pearson Correlation		.097	-.095
	Sig. (2-tailed) t-tests	.322	.332	
NEST	Pearson Correlation	.097		.148
	Sig. (2-tailed) t-tests	.322	.115	
MES	Pearson Correlation	-.095	.148	
	Sig. (2-tailed) t-tests	.332	.115	

Re-Examination of Byrd's NEST Scoring

Upon examining the statistical results of this survey, the researcher and the chair of the dissertation committee reviewed the scoring of the Byrd's NEST items. The scoring was originally done by a panel of three expert nurses, the scoring was revised according to the results of the small pilot study because a majority of the respondents fit the criteria for being an expert nurse but the scoring may not reflect expert nursing practice and this fact needed further analysis. Upon reviewing the

responses and the scoring, the scoring was revised. Table 14 reveals the changes in scoring and the final scoring of the instrument.

Table 14

Revised Scoring of Byrd's NEST P-3

Byrd's NEST Item #	Scoring	Revised Scoring
1	C=3 B=2 A=1	C=3 A=2 B=1
2	A=3 B=2 C=1	NO CHANGE
3	C=3 B=2 A=1	NO CHANGE
4	C=3 B=2 A=1	NO CHANGE
5	B=3 C=2 A=1	NO CHANGE
6	B=3 C=2 A=1	NO CHANGE
7	C=3 B=2 A=1	C=3 A=2 B=1
8	B=3 C=2 A=1	B=3 A=2 C=1
9	C=3 A=2 B=1	A=3 C=2 B=1
10	B=2 C=2 A=1	NO CHANGE
<i>Scoring Codes</i>		
Scoring of 3=highest ethical sensitivity		
Scoring of 2=medium ethical sensitivity		
Scoring of 1=lowest ethical sensitivity		

Pearson r Correlation of Byrd's NEST, MSQ, MES, and Variables (P-3)

The findings of the larger pilot study (P-3) were examined for correlations between the three tests used in this survey: the Byrd's NEST, the MSQ, and the MES; and between the Byrd's NEST, MSQ, and MES and the variables: educational level of the nurse, years of experience as a nurse, specialization in

nursing, and work setting of the nurse. There was only one variable that revealed statistical significance but the significance was between the MES and the nurse's specialization in the field of nursing ($p=.046$, $t=.203$). There were no other consistency noted between the variables and the three tests used in this survey. Table 15 reflects the data analysis of the correlations between the Byrd's NEST, MSQ, and MES with the variables.

Table 15

Pearson r correlation of Byrd's NEST, MSQ, and MES with the variables
($N= 115$)

	Ed Level	Years of Experience	Specialization	Work Setting
Byrd's NEST	-.028	.021	.010	-.051
MSQ	.032	.079	-.046	.106
MES	-.039	.138	.203*	.029

* $p<.05$

Internal reliability of Byrd's NEST items

The Byrd's NEST did not demonstrate internal consistency, scoring was reexamined and revised. The Byrd's NEST items did not reflect internal consistency in the responses even after scoring was revised. There is a presentation of Cronbach's alpha reliability coefficients for the Byrd's NEST items in Table 16.

Table 16

Reliability Coefficients of Byrd's NEST P-3 (N =103)

Item	Scale Mean If item Deleted	Scale Variance If Item Deleted	Corrected Item Total	Alpha If Item Deleted
NEST 1	23.2039	3.2031	.1151	-.0340
NEST 2	22.1553	3.0541	.0237	-.1146
NEST 3	22.9515	2.9094	.0519	-.1750
NEST 4	22.9612	2.9985	.0940	-.1856
NEST 5	23.0971	2.9121	.0018	-.1376
NEST 6	23.8252	2.6947	.0647	-.0662
NEST 7	23.1845	3.0735	.0407	-.0984
NEST 8	23.1845	3.1519	.1161	-.0260
NEST 9	23.0485	3.1643	.0311	-.1068
NEST 10	23.3786	3.1788	.0677	-.0794
Alpha = -.1174				

Participant Feedback for Improving Byrd's NEST Items (P-3)

The following are comments and suggestions received from the participants of this study.

Byrd's NEST #1

1) A 52 year old female has just been diagnosed with cancer but the doctor has ordered that the patient not be informed. The doctor does not to inform the patient of the diagnosis at the family's request. The patient is continuously asking about her condition and stating "I want to know if they have found something".

A	You talk to the patient, providing opportunities for her to discuss her thoughts and feelings about her condition and then discuss all possible diagnoses and offer options of treatment if it were cancer but refrain from telling the patient she has cancer.
B	You discuss her condition with her and inform her of the diagnosis of cancer. You stay with the patient to offer comfort and support.
C	You discuss the situation with the family and encourage them to tell her of the diagnosis of cancer. You place a call to the doctor to get permission to inform the patient, and offer to deliver the diagnosis if the family consents.

*Patient has the right to know but I would try to involve the family

*I would answer none of the above, "How about refer to ethics committee"

*Offered another answer choice-“Use chain of command, request ethics committee review”

Byrd's NEST #2

2) A 40 year old male patient who is an immigrant is being prepared to have surgery to treat lung cancer. The patient does not speak English but has signed the consent form. There is no family present. The patient nods yes to all questions but does not appear to understand what he is being asked. The nurse calls the surgery suite and the doctor to inform them that the consent is not valid. The doctor is infuriated and demands the patient be sent to surgery.

A	You refuse to send the patient to surgery and call for an interpreter.
B	You call the doctor, inform him of invalid consent, and page the nursing supervisor to deal with the situation.
C	You attempt to communicate with the patient, to inform to him that he is having lung surgery, and send him to surgery because the nurse knows it is in his best interests.

*One individual wanted to choose both A and B as responses

Byrd's NEST #3

4) A 23 year old male comes into the clinic for a pre-employment physical examination. Included in the examination is a urine drug screen and HIV test for AIDS. The patient is not aware he is being tested for AIDS. His test comes back positive. Protocol is to send the results to the employer.

A	You notify the nurse practitioner or doctor at the clinic, send the results to the employer, and document the results in the chart.
B	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he then turns and walks out of the clinic.
C	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he turns to walk out but you redirect him to a vacant room and ask the nurse practitioner or doctor to discuss these findings with him.

* Inform patient of test being authorized, “if choosing A-I would quit-it is not legal to obtain HIV without informing of test”

* “Not do the test without consent-patient can’t consent without being informed the test is being performed”

* “All patients are counseled before HIV tests are drawn in NY”

* “It is not lawful to test for HIV without consent-federal law covers counseling requirements”

- * "It is unethical for employer to test for HIV/AIDS without consent"
- * "Don't do test if he doesn't know what it is and how the results are reported"
- * "Protocol is not legal"
- * "This would be the NP/MD is the trainer; HIV counseling and you've asked the patient if he has talked to the NP/MD; choose B if engaged him in conversation before he leaves"

Byrd's NEST #4

5) A 95 year old female with a diagnosis of advanced dementia is a patient at an extended care facility in which you work. Several years ago, when she was more coherent, she stated repeatedly that she never wished to be kept alive by use of a feeding tube. Now she is unable to make decisions and has her niece as her surrogate decision maker. The niece consents to the insertion of a feeding tube placement and the patient is prepared to be sent for the procedure that afternoon.

A	You prepare the patient for the procedure because you understand that a feeding tube will provide for nutrition, fluids, and medications. This action is in the patient's best interest.
B	You attempt to contact the niece to relay information about the patient's wishes not to be kept alive by use of the feeding tube.
C	You notify the niece, the nursing supervisor, and the patient's doctor to relay the information that the patient did not wish to be kept alive by use of a feeding tube.

- * Assume no advanced directive & POA to niece-then choose A
- * Needs living will or advanced directive

Byrd's NEST #5

7) An 18 month old female is in the Pediatric Intensive Care Unit (PICU) under your care. She has suffered burns from a car accident. There is an emergency in the Emergency Room (ER) which requires your expertise and takes you away from your present duties. You are asked to go to the ER to assist. The child in PICU becomes extremely agitated when you leave her.

A	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.
B	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and then you call for someone else to assist in the ER and return to PICU.
C	You attempt to comfort the child in PICU first and then go to attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.

* "You do not leave a patient; continue to provide care

* "I have a conflict between B & C, either would work"

Byrd's NEST #6

8) A middle aged man is in front of you at the grocery store and falls to the floor. You realize in your assessment that he has stopped breathing and does not have a pulse. You initiate Cardiopulmonary Resuscitation (CPR). An ambulance arrives and a paramedic tells you he will take over. You realize the paramedic is incompetent and not performing CPR correctly.

A	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You resume CPR on the patient and tell the paramedic to call for backup assistance.
B	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You instruct him in the proper technique and stay until backup assistance arrives.
C	You inform the paramedic you are a nurse and assist in 2-man CPR.

* "I would direct the paramedic in 2 man CPR to ensure it's done correctly"

* Individual chose response C but added-"teach him CPR"

* "On the street, I am no better than the paramedic-calling for assistance is okay"

* "I have a responsibility to the patient, not the paramedic-I choose A"

* "Never seen a paramedic who couldn't do CPR"

Byrd's NEST #7

10) A 19 year old male is being admitted to the emergency room in extreme abdominal pain. When you palpate the RLQ, the patient hits you causing you to be slammed against the wall and fall to the floor. When you recover, you ask for another nurse to be assigned to his care. The other nurse who is assigned to care for him has gone to lunch and the patient is crying out in extreme pain, there are no other nurses available to assist in his care.

A	You attend the patient, evaluate his pain, and notify the nurse practitioner or doctor.
B	You attend to the patient and evaluate his pain. You document your observations and continue to monitor the patient.
C	You attend to the patient, evaluate his pain, and notify the nurse practitioner or doctor. You then call to get the test results, convey these results to the nurse practitioner or doctor.

* Comment - "He could be charged with assault"

Byrd's NEST #8

11) A 25 year old female is being seen at your clinic for treatment of schizophrenia and is presently is becoming agitated because of paranoid delusions and having auditory hallucinations. She also has a diagnosis of mental retardation and has developed to a mental age of about 4 years. The nurse prepares to give her an injection of antipsychotic medication when the patient becomes hysterical. The nurse is not able to give the injection and notifies the ordering practitioner. The practitioner tells you to give the injection to her no matter what it takes.

A	You attempt to talk to the patient at a level she will understand and persuades her to calm down. You then attempt to administer the shot with assistance of other office personnel but she becomes hysterical again. You then goes back to the ordering practitioner.
B	You obtain assistance from other office personnel, enter the room, and talk to the patient. When she has calmed down, you tell her you are going to give her the injection, and administer the injection even though she starts to become hysterical when she sees the shot needle.
C	You obtain assistance from other office personnel and administers the injection. This medication is given in the patient's best interest and you know she would not understand even if you tried to explain it to her.

* "This patient would not be unaccompanied, have the care provider calm and then administer

"A legal order called a 'Rogers' is required otherwise cannot medicate"

Byrd's NEST #9

13) At the health department in which you are employed, a 16 year old mother brings her child to be seen because she is complaining of abdominal pain. Upon examining the 4 year old female child, you observe that she is very quiet and allows you to examine her without hesitation. You note that the hymen is not intact, there is swelling in the vaginal area, and you suspect sexual abuse. You convey your findings to the mother who seems annoyed by your accusation. (The 16 year old mother is the daughter of the doctor who staffs the clinic)

A	You document these findings, notify the head nurse of the clinic, and summon the police to file a report.
B	You document these findings, notify the doctor which is the child's grandfather, and ask for further orders.
C	You document these findings, notify the doctor which is the child's grandfather, and inform him that these findings will be reported and a police report will be filed. You allow the doctor to speak with the mother and child.

* Chose A but added "notify social worker/child abuse worker

* "Sexual abuse suspicion is mandatory reporting"

* Chose A-notify police department or child protection services-what is hospital protocol for reporting child abuse? Nurse has responsibility to assure the report is made but this could be via hospital protocol

* In Maine, Call department of social services

Byrd's NEST #10

14) You are shopping when you overhear two very young girls talking. One girl tells the other girl (who is pregnant) that drinking alcohol, taking aspirin, and consuming anti-freeze will cause her to have an abortion. You know the mother of the pregnant teenage girl.

A	You call the mother of the pregnant teenage girl to inform her of what you heard because you know it is in the girl's best interest.
B	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You do not tell the girl's mother because this would be a breach of confidentiality.
C	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You then call the girl's mother to inform her of what you heard in order to protect her.

* "Answer depends on the age of the 'very young girl' - 17 or 13? "What is the relationship between the girl and mother?" I would also tell her how it affects the unborn child and offer to help her find help if she wants to learn about abortion

* "I would choose C & (added) take the girl and ask her to go with her to her mother-technically this is not breach of confidentiality-this is a friend to friend help not necessarily help from a nurse-patient relationship"

* "Not enough info-what is the age of the girl?"

* "How young?"

Revised Byrd's NEST – Current Version

The Byrd's NEST was then revised from the findings of the larger pilot study, the statistician, and the chair of the dissertation committee. A final version has been created (see Appendix A). All revisions are in bold print. The scoring for the final version is presented in Appendix Q.

Research Question 1

What are the psychometric properties of the instrument: Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST)? See Tables 13 and 15 for the specific data analysis.

The results of the large pilot study (P-3) revealed that all the nurses responding to the survey measured high on the ethical sensitivity scores, averaging 24 out of a possible 30. The Byrd's NEST was assessed for correlation with the MSQ (Lutzen et al., 1997) and the MES (Reidenbach & Robin, 1990) for concurrent validity. There were no correlations found between the scores of the Byrd's NEST and the MSQ or of the Byrd's NEST and the MES. Pearson r correlation of the Byrd's NEST with the MES was .148; correlation of the Byrd's NEST with the MSQ was .097; and correlation of the MES with the MSQ was .095. The Byrd's NEST instrument did not reveal internal consistency within the test items. The items in the Byrd's NEST were revised according to the comments/suggestions made by those returning the survey to create the final version of the Byrd's NEST, which will require further testing.

Research Question 2

Is the ethical sensitivity of nurses related to educational level in nursing? See Table 15 for the specific data analysis.

There were no correlations found in this survey between the ethical sensitivity scores and the educational level of the nurse using the Byrd's NEST, the MES items, and the MSQ items. Pearson r correlation between the educational level of the nurse and the Byrd's NEST was inversely correlated

-.028; correlation between the educational level of the nurse and the MSQ was .032; correlation between the educational level of the nurse and the MES was -.039. These findings were not consistent or statistically significant amongst the 3 different tests and the educational level of the nurse.

Research Question 3

Is the ethical sensitivity of nurses related to years of experience as a registered nurse? See Table 15 for the specific data analysis.

There were no correlations found in this survey between the ethical sensitivity scores and the years of experience as a nurse using the Byrd's NEST, the MES items, and the MSQ items. Pearson r correlation between the years of experience of the nurse and the Byrd's NEST was .021; correlation between the years of experience of the nurse and the MSQ was .079; correlation between the years of experience of the nurse and the MES was .138. These findings were not consistent or statistically significant amongst the 3 different tests and the years of experience of the nurse.

Research Question 4

Is the ethical sensitivity of nurses related to specialization in the field of nursing? See Table 15 for the specific data analysis.

There was a statistically significant correlation between the ethical sensitivity scores of the MES and the specialization in the field of nursing at ($t=0.203$, $p<.05$). There were no correlations found in this survey between the ethical sensitivity scores and specialization on the field of nursing using the Byrd's NEST and the MSQ items. Pearson r correlation between the nurse's specialization in the field of nursing and the Byrd's NEST was inversely correlated

-.323; correlation between the nurse's specialization in the field of nursing and the MSQ was .081; correlation between the nurse's specialization in the field of nursing and the MES was -.111. These findings were not consistent or statistically significant amongst the three different tests and the years of experience of the nurse.

Research Question 5

Is the ethical sensitivity of nurses related to the work setting of the nurse? See Table 15 for the specific data analysis.

There were no correlations found in this survey between the ethical sensitivity scores and the work setting of the nurse using the Byrd's NEST, the MES items, and the MSQ items. Pearson r correlation between the work setting of the nurse and the Byrd's NEST was inversely correlated -.051; correlation between the work setting of the nurse and the MSQ was .106; correlation between the work setting of the nurse and the MES was .029. These findings were not consistent or statistically significant amongst the 3 different tests and the years of experience of the nurse.

CHAPTER V

SUMMARY

Discussion, Conclusions, and Recommendations

The purpose of this dissertation was to develop and analyze the psychometric properties of Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST), an instrument intended to evaluate nurses' ethical sensitivity in practice by examining their choices of action in ethical dilemmas. The scenarios were based on Benner's nursing virtues: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Benner et al., 1996; Volbrecht, 2002). In this chapter, the following sections are presented: an overview of the study, interpretation of the findings, implications for social change, recommendations for action, recommendations for further study, and conclusions of the study.

Overview of the Study

The specific purpose of this study was to present the steps in instrument development and assessment of the psychometric properties of this newly developed instrument, Byrd's NEST. Developing an instrument, such as the Byrd's NEST, is a long and arduous process which can take years to refine so that it has an acceptable reliability and validity. The instrument went through several phases in development and assessment and all research questions were answered as a result of this dissertation process. However the refinement process is not complete because at the end of this dissertation process the instrument currently did not demonstrate acceptable reliability for assessing nurses' ethical sensitivity in practice. The instrument needs to improve its validity for assessing

ethics in nursing practice; two different panels of experts and many of the respondents to this survey agreed that the instrument was a useful tool in assessing ethics in nursing practice. The instrument needs further refinement through testing until an acceptable internal consistency and reliability can be documented.

Rationale for Dissertation

This study was undertaken because, first, there is no instrument that is specific to nurses' degree of ethical sensitivity in practice, and second, developing an instrument to reflect a nurse's degree of ethical sensitivity in practice could lead to a greater understanding of the virtues of nursing practice. Ultimately nurses practicing with a greater degree of ethically sensitivity and morally justifiable care could lead to more improved evidenced-based patient outcomes.

In nursing education, there has been increased interest in nursing faculty's teaching moral self-awareness, ethical responsibility, and nursing virtues (Karseth, 2004). The fact that there is more emphasis on nurses' moral self-awareness, ethical responsibilities, and virtuous care in practice in the *Code of Ethics with Interpretive Statements* (ANA, 2001) helps to support more integration of these concepts in nursing education. Even more importantly, the Association of American Colleges of Nursing ([AACN], 2004) and the National League of Nursing Accrediting Commission ([NLNAC], 2003) revealed a need for more integration of ethics and ethical decision making strategies in nursing school education across the country. Butts and Rich (2005) in the preface of their book emphasized the need for more ethics education:

Nurses must be prepared to attach their own meanings to life and death, and nursing students and practicing nurses need to acquire foundational knowledge about ethics and decision-making strategies to prepare them for the moral issues that they experience daily. (p. xiii)

Once an acceptable level of validity and reliability are documented for this instrument, the scenarios that are incorporated on the Byrd's Nest could be integrated in nursing curricula by way of clinical student conferences, inquiry, and classroom dialogue of case studies.

Brief Description of the Instrument Development

Instrument development was the focus of this dissertation in which the researcher went through multiple phases in developing, testing, and refining the Byrd's NEST. The stages of testing psychometric properties in the development process are well articulated in this dissertation. The instrument itself did not reflect an acceptable reliability at the end of this dissertation process. However the instrument is still a work in progress and more testing and refining are needed.

During the development of the instrument input was received as a result of the different testing procedures and revisions were made to the instrument to improve its validity and reliability. The following describes the different stages of development.

1. Byrd's NEST P-1—the preliminary version of the instrument. Two panels of experts analyzed the instrument for item construction, content validity, face validity, and clarity (or readability of questions).
2. Byrd's NEST P-2—the second version of the instrument was used for the small pilot study. A pilot study with a convenience sample of 20 nurses whose

data were examined for: (a) concurrent validity of the 10 items from the MSQ (Lutzen et al., 1997) and the Byrd's NEST; (b) concurrent validity of the 5 questions adapted from the MES (Reidenbach & Robin, 1990) and the Byrd's NEST; (c) test-retest reliability (stability) in which the identical form of the instrument was used for the retest with this same group of 20 nurses, approximately two weeks apart; and (d) a sequence of correlations between variables—ethical sensitivity scores and educational level in nursing, ethical sensitivity scores and years of experience in nursing, ethical sensitivity scores and specialization in nursing, and ethical sensitivity scores and work setting of the nurse.

3. Byrd's NEST P-3—the third version of the instrument was used in the large pilot study. This questionnaire was sent to 500 registered nurses and 117 responded. A random sample originated from the ANA's membership list. The findings were tested for correlations between the Byrd's NEST and the other two tests, which were the MSQ and MES. The first correlation test was for concurrent validity. Then a sequence of correlations were conducted between variables—ethical sensitivity scores and educational level in nursing, ethical sensitivity scores and years of experience in nursing, ethical sensitivity scores and specialization in nursing, and ethical sensitivity scores and work setting of the nurse.

Interpretation of the Findings

In this section, an interpretation and conclusion of the findings of the research questions are presented along with other data related to the sample. A presentation of findings as related to the larger body of literature, including the theoretical framework, is also presented.

Developing and Assessing the Psychometric Properties

Steps in developing and assessing the Byrd's NEST are presented in this section. A search of the literature was performed by searching CINAHL, Medline, and other databases at The University of Southern Mississippi's (USM) Library and the Georgetown University Bioethics Library. Additionally, the Dissertation Abstracts from 1861 to present were searched. There was minimal response when the question of a definition of nursing virtues was asked by this researcher on a nursing internet METRIC message board, which is a forum of inquiry for deliberating with expert nurses about the nursing professional. There were no instruments found to analyze ethical decision making that is unique to nurses.

Based on the review of literature, the review of ethical dilemmas in nursing practice, and the researcher's 20 plus years of nursing experience, the researcher created 10 items with scenarios that consist of ethical dilemmas in nursing practice followed by three multiple choice responses. The participants were to choose the course of action that was consistent with what they would do in this dilemma. Each choice of action was scored on a scale of a high, medium, or low degree of ethical sensitivity. The different virtues in nursing were presented in the scenarios. Also included in this testing phase were 10 items that were adapted from the Moral Sensitivity Questionnaire ([MSQ]; Lutzen et al., 1997) and 5 scenarios adapted from the Multidimensional Ethics Scale ([MES]; Reidenbach & Robin, 1990). These 15 items were added by the researcher to test and document the degree of concurrent validity.

Testing of the Byrd's NEST included evaluation of the instrument for item construction, content validity, face validity, and clarity (or readability of questions).

Reliability and validity tests were conducted throughout the developmental process in three stages. This large pilot study was conducted to assess the psychometric properties of the Byrd's NEST and to see if there were correlations with the variables.

The scenarios of the adapted instrument—MES—had similar structure and wording to the scenarios of Byrd's NEST and were scattered throughout the survey so they could not be distinguished as originating from a different source. The MES was developed by Reidenbach and Robin (1990) as a way to measure ethics in the business discipline. The five scenarios that were adapted from this instrument were integrated throughout the Byrd's NEST. These scenarios were changed to scenarios in nursing practice. The items from the MES were used to establish concurrent validity since they were testing for a similar construct (ethical sensitivity in the business arena) as the Byrd's NEST, which was used for measuring ethical sensitivity in the nursing arena.

The MSQ was developed by Lutzen, Everton, and Nordin (1997) as a way to measure the moral sensitivity decision making of nurses working specifically in mental health and psychiatric settings. The decision making was scored on a Likert-type scale of 1 to 7, from most agreeable to most disagreeable. The MSQ was intended for use in psychiatric nursing. Sometimes decisions are made against the self-determination of the patient because of the patient's potential for self-harm. The statements regarding making decisions against the self-determination of the patient were scored differently for this study; that is, in a reverse scoring method. There were a total of 5 of the 10 adapted items that were reverse scored. In other words, any statements that would encourage a nurse to

go against the self-determination of the patient was reverse scored because patient autonomy and self-determination are emphasized concepts in the Western part of the world, especially in the United States where the Patient Self-Determination Act of 1990 is legally enforced.

The intention of the MSQ developers was for the instrument to measure moral sensitivity in psychiatric nurses. Even with an attempt to overcome the issues of using the MSQ to document concurrent validity, there still were problems noted with the internal consistency measurement of the MSQ items in the pilot study. For the scoring in this study, the Likert-type scale was used to assess a nurse's degree of agreement to disagreement. However instead of the responders agreeing or disagreeing with the statements on a scale of 1 to 7, wording was added and the scale was changed to reflect a 5-point Likert-type scale with 1 being completely agree to 5 being completely disagree. The following weighted choices were used: completely agree, somewhat agree, agree, somewhat disagree, completely disagree.

Besides the low concurrent validity scores, another problem emerged and compounded the issue. There was an error in a portion of MSQ, and the questionnaire with the error was sent as part of Byrd's NEST P-3 to the 500 nurses in the large pilot study. Because of the error, the actual scale that was sent consisted of these choices: completely agree, somewhat agree, agree, somewhat agree, completely agree. Somewhat disagree and completely disagree were accidentally omitted, and somewhat agree and completely agree were replicated. This typing error first was noted by one responder who notified by telephone call the administrator of the Institutional Review Committee at USM. Then several

responders of the instrument wrote in *dis* beside the incorrect choices on the instrument thus correcting the error. All questionnaires (N=107 participants) that were returned and surveys that had the Byrd's NEST, MSQ, and MES sections completely answered were included in the data for analysis but any specific items without being answered or without the penciled-in corrections of the error on the MSQ scale (referenced above) were not included in the data for analysis (8 respondents did not correct the MSQ items).

The Byrd's NEST P-3 was reviewed for comments from the respondents, the scoring was reviewed, and the response scoring was reevaluated to make final revisions to the Byrd's NEST. This process was meant to improve the instrument for further testing. The final version of the Byrd's NEST instrument consists of 10 ethical dilemmas in nursing practice. The scenarios are followed by three multiple choice responses to allow the participant to choose a course of action scored on a scale of a high, medium, or low degree of ethical sensitivity.

Stages of Assessment of the Byrd's NEST

In this section, the specific stages of development are presented. The three stages of development consist of psychometric testing that was completed to answer the research questions.

Stage 1

This first stage of the initial instrument testing is called Byrd's NEST P-1. In the P-1 form, the instrument was presented to two panels of experts in which they made feedback for improvements to the instrument. Minor wording changes were made to decrease responder bias and adjust the MES item scenarios, which were used to concur validity, to a more similar wording as the scenarios that were

created by this researcher for the Byrd's NEST. Also some of the demographic data items were adjusted to remove the extraneous and non-needed information. The first scores the Byrd's NEST was produced by the panel of nursing experts, yielding a .67 inter-rater reliability. At the suggestion of the statistician on the dissertation committee four scenarios were revised. These scenarios were resubmitted to the panel of nursing experts and the items rescored which yielded a .76 inter-rater reliability for the instrument, an acceptable level of reliability. After revisions were made, Byrd's NEST P-2 was created.

Stage 2

A small pilot study was conducted using Byrd's NEST in the P-2 form with a convenience sample of 20 nurses in which the response rate was excellent (75%, N=15). There was poor correlation of the Byrd's NEST with the MSQ items (Pearson $r = -.144$) and the Byrd's NEST with the MES items (Pearson $r = .412$). Cronbach's alpha for internal consistency was $-.1177$. At recommendations from the statistician on the committee, the large pilot study (P-3) was undertaken but the Byrd's NEST was analyzed for ways to improve the instrument.

Sixty-nine percent of nurses in this small pilot study fits the criteria of expert nurses and because of the nurses' expertise, the findings from this sample influenced the researcher's revising the scoring. The scores comparing the initial test and the re-test survey reflected minimal reliability between the test and re-test (stability) (Pearson r : Byrd's NEST .176, MES .361, and MSQ .159). From the feedback offered by the respondents in P-2, minor wording changes were made to the scenarios and some rewording of responses to remove consequences of actions were made in an attempt to decrease responder bias. Also, an item was

added in the demographic data section for the participants to answer in the survey of the larger pilot study, P-3, to investigate the presence of ethics education in nursing programs. From these revisions, Byrd's NEST P-3 was created.

Stage 3

The large pilot study of 500 nurses from the membership of the American Nurses Association (ANA) was conducted by asking the participants to complete the Byrd's NEST in the P-3 form. A 24% (N=115) return rate of the survey was noted. Initial analysis revealed a poor internal consistency with scores of individuals items ranging from $-.2281$ to $.1522$. Acceptable scoring would have been at least $.60$ for a large pilot sample such as this study (Polit & Hungler, 1995). There were not acceptable levels of concurrent validity when comparing the Byrd's NEST and the items from the MSQ items (Pearson $r .097$), as well as the Byrd's NEST and the items from the MES (Pearson $r .173$). Pearson r is a widely used correlation coefficient designating the relationship between two variables on an interval scale (Polit & Hungler, 1995).

After reviewing these results, the researcher and the chair of the dissertation committee reevaluated the total scoring and each item's scoring of the instrument. The scoring was reviewed for accuracy of scoring according to the virtues identified by Benner and was revised accordingly. After the scoring was revised according to the reevaluation changes, the Byrd's NEST still did not reflect an acceptable level of internal consistency (with the individual item scores ranging from $-.1161$ to $.0940$). Suggestions were made to revise certain items in the instrument by the chair of the dissertation committee. Also, suggestions from the respondents who returned surveys were considered when creating the current

version of the Byrd's NEST. Byrd's NEST items 3, 6, 8, and 10 were revised, see final version of Byrd's NEST (Appendix A). It should be noted here that the creation of a good instrument often takes years and this phase of instrument development was only the beginning of the process.

The Research Questions

At the inception of this undertaking, there were no instruments found for assessing ethics in nursing practice, which let the researcher to conclude that there was a great need for one. Based on this finding, the researcher aspired to develop an instrument. Two questionnaires—MSQ and MES—were used for concurrent validity but these questionnaires were not intended to assess ethics in general nursing practice and may not have been reliable for assessing this construct. However the researcher had no other instruments for testing concurrent validity and chose to use them because they were the closest to assessing the construct of ethics in nursing practice.

Further testing and refinement of the Byrd's NEST will be necessary but these instruments will no longer be used. The internal consistency and concurrent validity between the MSQ and the Byrd's NEST and the MES and the Byrd's NEST were not acceptable levels. For future use of the Byrd's NEST, the items from the MSQ and the MES will be deleted from the instrument. Additionally, 2 of the scenarios included in the Byrd's NEST were not dilemmas in nursing practice; rather, they were set outside of a practice setting and therefore not reflective of nursing practice. Upon further refinements, another panel of nurses will be asked if these scenarios should be changed to a nurse practice setting or be deleted from the survey.

Research Question 1

What are the psychometric properties of the instrument: Byrd's *Nurse's Ethical Sensitivity Test* (Byrd's NEST)?

The scores of the participants in the large mail-out of 500 nurses were all high, possibly demonstrating a ceiling effect in which the different group's characteristics could not be differentiated. The Byrd's NEST did not reflect an acceptable level of internal consistency (Cronbach's alpha ranging from $-.1161$ to $.094$ among the items). There were not acceptable levels concurrent validity with the MSQ items (Pearson r correlation $.097$) and with the MES items (Pearson r $.148$). At this stage of development of the Byrd's NEST, it is not a reliable or valid instrument. Further revisions and testing are required if the instrument is to develop sound psychometric qualities and be disseminated to nurses.

Research Question 2

Is there a relationship between the ethical sensitivity scores of nurses and educational level in nursing?

In this study, there was no relationship between the ethical sensitivity scores of nurses and their educational level in nursing (Pearson r $-.028$). It was hypothesized by the researcher that RNs who seek advanced degrees in nursing will have an intention to practice with more ethical sensitivity.

Research Question 3

Is there a relationship between the ethical sensitivity scores of nurses and years of experience as registered nurses?

In this study, there was no relationship between the ethical sensitivity scores of nurses and their years of experience in nursing. Although no relationship

was found in this study (Pearson $r = .021$), the researcher hypothesized that years of experience will expose a nurse to a variety of situations and ethical dilemmas, which would hopefully lead to a working RN better prepared to analyze such dilemmas.

Research Question 4

Is there a relationship between the ethical sensitivity scores of nurses and specialization in fields of nursing?

In this study, there was no relationship between the ethical sensitivity scores of nurses related to their specialization in fields of nursing (Pearson $r = .012$). However, the researcher hypothesized that nurses seeking additional education and pursuing specialty certifications in nursing will progress to an expert level of practice, if they have not done so already, which in turn will promote higher ethical sensitivity in nursing practice.

Research Question 5

Is there a relationship between the ethical sensitivity scores of nurses and the work setting of the nurse?

In this study, there was no relationship between the ethical sensitivity scores related to work setting of the nurse (Pearson $r = -.051$). This researcher hypothesized however nurses' work setting would influence the degree of ethical sensitivity in nursing practice.

Comments by Participants of the Large Pilot Study: 500 mail-out survey

Twenty-nine percent ($N=34$) of those returning the surveys, requested to receive the results of the survey. Several comments were written on the surveys in which participants indicated a positive interest in nurses investigating ethical

sensitivity in nursing practice. Two nurses sent information about their ethics committees. There were no negative responses about the questionnaire or the items but many nurses offered feedback to improve the responses. The positive comments, constructive criticism, and the lengths that a couple of the participants went to for explaining their ethical practice, such as the two nurses sending information about their ethics committees, substantiated this researcher's stance that ethical sensitivity in practice, as well as measuring ethical sensitivity, are critical elements that are need to promote better patient outcomes.

From the positive responses, one participant wrote that she was an oncology nurse who was interested in beginning a navigator program for patients at her facility. The participant stated: "Ethics is a very important facet of nursing, on behalf of all the nurses I know, thank you for delving into this difficult matter."

Another comment was that the scenarios were very interesting. The participant wrote: "...of course no situation is black and white but all of these things do happen out there" in reference to the scenarios presented in the survey.

Theoretical Framework: Benner's Theory

The structure of the instrument and the response choices for the instrument were based on Benner's theory of skill acquisition in nursing—novice to expert—and on the virtues used in nursing practice that were identified by Benner, which included: compassion, fidelity to trust, moral courage, justice, self-confidence, resilience, practical reasoning, and integrity (Benner et al., 1996; Volbrecht, 2002). A review of literature was performed to investigate ethics in nursing practice and to determine if there were any instruments specific to nurses to measure ethics or ethical sensitivity. At the time that this dissertation was begun there were no other

instruments found in which nurses' ethics, nurses' ethical sensitivity, or ethics related to the virtues of nursing practice could be measured.

This study was based on Benner's theory on skill acquisition in nurses. In other words, a nurse passes through five levels of proficiency: novice, advanced beginner, competent, proficient, and expert (Benner, 2001). These five levels reflect changes in three general aspects of skill performance and ethical thinking. The first level, novice, is a movement from reliance on abstract principles to incorporating concrete experiences into practice. The second level, advanced beginner, is a change in the learner's perception of a situation, from a collection of equally relevant bits of information to a compilation of parts that are relevant to the situation to create a whole picture. The third level, competent, is a passage of a detached observer to an involved performer where the individual no longer stands outside of a situation but is engaged in the situation. The fourth level, proficient, is exemplified when a nurse perceives a situation as a whole entity rather than in terms of individual.

By the time nurses reach the fifth level, expert, and are practicing as expert nurses, they perform competently by deliberating with others and pondering choices. By knowing what actions need to be taken in any given ethical situation, expert nurses will act virtuously because of having already developed the wisdom to do so. Benner (1996) rated the strong similarity of Aristotle's practical wisdom to the expert nurse's potential to make excellent decisions in ethical situations. Benner advocated that the development of clinical expertise demands the development of moral or ethical expertise.

Benner, Hooper-Kyriakidis, and Stannard (1999) believed that for nurses to acquire ethical expertise, they must first be at an expert level of practice to respond to ethical situations. By creating an environment that supports the nurse's development of virtues expert nurses will have a favorable influence on patient care and outcomes (Corrigan-Wandell, 2003).

The results of this survey indicated that all nurses who responded in this study demonstrated very high ethical sensitivity scores according to the Byrd's NEST, scoring averaged 24 or higher on the actual Byrd's NEST items out of a possible score of 30, regardless of their educational degrees, years of experience, specialty certification, or type of work setting. However, the sample may have been skewed. It was found that 89% of the sample had greater than 10 years of experience as a nurse, 90% of the sample had a BSN or higher degree with 55% having a MSN or higher, and 87% of the sample had specialty certification making a majority of the nurses fit the criteria of expert nurses according to Benner. It could mean that those nurses interested in ethics decided to participate in this survey and ethical sensitivity issues may have been more important to their nursing practice.

There were positive correlations, though not acceptable levels, between the Byrd's NEST scores and the following: total years of experience as a nurse (.021) and specialty certification of the nurse (.012). However there were inverse correlations between the Byrd's NEST and: the educational level in nursing (-.028) and work setting of the nurse (-.051). On the demographic data there was a question about ethics education in nursing programs. From that demographic data

finding, an inverse correlation was found between the Byrd's NEST and ethics education in nursing programs (-.051).

The rationale for these non-significant and inverse correlation scores could be related to two factors. One contributing factor is that Benner's (1996) proposition that there is a relationship between a nurse's virtuous (ethical) practice and the following: years of experience, specialty, work setting, and higher educational levels may not be either not generalized to the wider population of nurses or the proposition may be incorrect. Benner's study (1996) of identification of virtues in nursing practice was based on a qualitative study that could not supposedly be generalized to other samples or populations. The general consensus by nurses who are considered experts in practice is that the previously mentioned variables do influence expert nursing practice. Therefore, this researcher will continue to strive for conceptual consistency between Benner's theory of skill acquisition and the instrument.

Another contributing factor may be in the lack of internal consistency of the Byrd's NEST instrument. The researcher believes that expert nurses exhibit higher ethical sensitivity in practice when faced with nursing dilemmas. As a whole, the researcher has extrapolated from these findings that the nursing profession is an ethical practice. As ethics education and awareness of ethical sensitivity in nurses are becoming more apparent in nursing programs and in practice, the nursing profession's stance as an ethical practice will become more intensified.

Limitations of the Study

The development of the Byrd's NEST had a relatively short time frame and developing an instrument generally involves a much longer process. There needs to be a deeper analysis of the dilemmas and response choices. As communicated in the last section of Chapter 5, it is clear that the respondents (N=107) scored on the high end of ethical sensitivity. This finding means that the scores could have reflected a "ceiling" effect (Graziano & Raulin, 2000). Rationales that may be considered are presented next.

A ceiling effect usually results in meaningless findings, and if this effect occurred, more discrimination in the responses and more depth to each dilemma need to be added. The sample was a random sample of 500 registered nurses who have membership in the American Nurses Association. Of the 107 respondents in the survey, a large majority of them held master's and baccalaureate degrees. However, working RNs do not reflect these statistics.

The National Advisory Council on Nursing Education and Practice (2002) reported statistics on the education level of working RNs in 2000, which revealed that only 44% of working RNs held a baccalaureate or higher degree. Nurses with master's degrees were very small in comparison. Because the sample is not representative of the larger population of working RNs, the researcher must evaluate if the majority of the respondents would practice more ethically just because of the exposure to more education thus producing this ceiling effect. And if so, would this mean that there is a high correlation between education level of nurses and ethical sensitivity in nursing practice even though a negative correlation was found in this study.

Other explanations are offered. Response choices and the dilemmas could have been too limiting and may not have reflected an adequate level of difficulty for nurses choosing the correct responses. The response choices may not have been varied enough to encompass fully what a nurse would actually desire to do in each specific scenario. There may not have been enough information provided in each dilemma to assess accurately the situation.

The sample may have been skewed because the respondents had markedly high educational levels, years of experience, and specialty certification, not representative of the general nursing population in the United States. There is another explanation that is related to cultures and values. Though this random sample was from the United States, RNs who responded may have an Eastern origin, or a perspective unlike what is valued in the Western world. One such example is autonomy, which is generally extremely valued by people originating from the United States and other parts of the Western world and for the most part not as valued by people with an Eastern origin. Because the development of the Byrd's NEST was processed from a Western perspective of nursing practice, the virtues valued by this researcher may not be reflective of virtues valued by nurses who have origins from other areas of the world. The scenarios and the response choices for the Byrd's NEST may vary with different cultures.

Implications for Social Change

Social change needs to occur in and out of the nursing profession. Many nurses do not realize or are confused about their own ethical sensitivity levels and their ethical obligations to patients. It could be that they do not understand their level of independence to influence decisions in ethical dilemmas (Habel, 2005).

Many nurses have the ability to make logical and rational ethical decisions but they may fear reprisal by their employer if they voice their disputes, so they silently conform to institutional and administrative opinions and policies. Nurse researchers and educators must help teach nurses and nursing students of their ethical obligations to patients.

Nursing is an ethical practice as evidenced by the high ethical scores of the Byrd's NEST survey and the nursing profession should continue to strive for nurses to become more ethical by understanding ethics in nursing practice and seeking ways to foster such practices. By reviewing the literature this researcher found several authors in agreement that a greater understanding of the virtues in nursing practice could lead to better nursing care by a provision of ethically sensitive, morally justifiable care (Benner et al., 1996; McAlpine et al, 1997; Smith, 2005). Registered nurses completing the Byrd's NEST exposed them to dilemmas in practice they may otherwise not have seen, which facilitated these nurses to evaluate their own ethical sensitivity and ethical choices they would choose. Bringing ethical issues to light is imperative to verify nursing ethics as a distinct field with its own values and virtues. The development of an instrument to assess nurses' ethical sensitivity in nursing practice is a step towards communicating the ethical obligations of nurses within the nursing profession and to people entering the nursing profession as well as those people outside the nursing profession.

Recommendations for Action

The creation of the Byrd's NEST exemplifies the first steps in a long process of instrument development. This process has not reached completion. For Byrd's NEST to be disseminated to nurses, the instrument needs to be revisited, revised,

and tested again until the psychometric properties are measured at a more acceptable level. Information about the ethical sensitivity of nurses in practice may be the worthy for the American Nurses Association, the International Council for Nurses, Institute of Bioethics, and other nursing organizations as well as ethics organizations. This type of information could also be useful to nursing administrators, continuing education professionals, and nursing faculty. Many nursing educational organizations could find the information on development of instrument useful.

Implications for Nursing Practice

The degree to which nurses are ethically sensitive in their practice could affect patient outcomes. In a recent South Korean study of ethical sensitivity in staff nurses, Kim, Park, You, Seo, and Han (2006) contended that to practice with ethical sensitivity, nurses are required to be knowledgeable about specific situational aspects, and if these situations are not managed with adequate sensitivity, the welfare and wellbeing of patients could be severely affected. Some of the ethically sensitive behaviors that Kim et al. recognized as important include “insight, intuition, moral knowing and the ability to recognize the salient moral cues in any given situation where a moral issue exists” (p. 594).

Kim et al. (2006) developed a 14-item instrument to measure ethical sensitivity. Four of the items were on personal concerns, five items were on ethical standards, and five were on organizational rules. Overall, the 236 nurses scored a mean of 0.71 of 1.0 on ethical sensitivity, which indicated that they scored very high on ethical sensitivity. Though different questions were asked and the participants were from a different part of the world, this high score of ethical

sensitivity in Kim et al.'s study is consistent with the findings in this researcher's study. If the findings can be generalized as a result of the additive effect of the two studies, then a conclusion can be drawn that in general nurses practice with a great degree of ethical sensitivity.

Of the 236 nurses who responded to Kim's et al. (2006) survey, 68.2% said that they sometimes get confused regarding ethical values. Even though 97.9% of nurses believed that they had a moral responsibility to recognize ethical nursing issues, most of them (86%) stated that they had difficulty making ethical decisions and a large majority (65.3%) reported that they rely on their co-workers' opinions and rely (60.6%) on their personal values for solving ethical dilemmas.

As did Kim et al. (2006) found, Habel (2005) stated that confusion of the ethical values and issues is an issue with nurses. Ethical issues that are unfamiliar to nurses, that may not have been addressed during the educational process, or that has not been encountered at any point in the nurse's current career may cause confusion and frustration in the working environment.

Kim et al. (2006) found two significant differences in their study, one of which is noteworthy for this researcher's study. Out of a high possible score of 1, Kim et al. found that nurses between the ages of 25 and 30 years reported a significantly greater degree of ethical sensitivity, a mean score of 0.73 than nurses less than 25 years old who had a mean score of 0.69 or nurses greater than 30 years old who had a mean score of 0.69. The authors suggested that the very active clinical practice of nurses between the ages of 25 and 30 years could be an influencing factor for this finding. In previous dissertation and thesis studies in Korea, the older the nurse is, the higher the degree of ethical sensitivity (e.g. Kim,

1999; Park, 2002; as cited in Kim et al., 2006). Kim et al. (2006) emphasized that their small sample of nurses over the age of 30 could have affected the findings of that segment of nurses.

Ethical behaviors can be learned through exposure to case scenarios involving ethical dilemmas in nursing practice, whether through group discussions, role-playing, examples from mentors, or through educational programs. Inquiry and deliberations of situational ethical dilemmas such as those listed in the Byrd's NEST can be carried out in hospital clinical conferences and team meetings. Nurses who can think reflectively about and deliberate specific ethical dilemmas could promote a greater confidence in their decision-making abilities when such dilemmas actually occur.

Implications for Nursing Education

There has been a move by nursing faculty to teach more moral and ethical content in nursing programs in the recent years (Karseth, 2004). As evidenced in ANA's *Code of Ethics with Interpretative Statements* (2001), a greater emphasis is now on virtuous nursing practice, as virtues such as integrity, compassion, courage, honesty, and many more have been identified as important in the life of nurses in practice. The virtues and values stated in ANA's *Code of Ethics with Interpretative Statements* (2001) need to be accentuated with nursing students early in and throughout their nursing programs. As previously stated in Chapter 5, the AACN (2004) and the NLNAC (2003) have recommended that more ethics and ethical decision-making strategies be integrated in nursing curricula. These recommendations also have sparked great interest in ethics education in nursing

schools. Ethics education is extremely necessary for nursing students to grasp an early self-awareness of ethics in practice.

Practicing nurses also need to clarify their ethical obligations to patients and to the nursing profession. Because confusion of ethical values in nursing practice has been recognized in at least two nursing ethical studies recently (Kim et al., 2006; & this study), practicing nurses need to participate in deliberations to clarify ethical values, issues, and appropriate courses of action. It is not unusual for working RNs to be unfamiliar with or even unaware of the existence of ANA's newer and current *Code of Ethics with Interpretative Statements* (2001), as evidenced by RNs returning to school for higher education at a university in Southern Mississippi (J. B. Butts, personal communication on March 1, 2006). Could it be that this observable fact is a trend across the country? If so, this unfamiliarity could be a contributing factor in working RNs' confusion about their ethical sensitivity levels, which is a documented finding in Habel (2005) and Kim et al. (2006).

Assessment of ethical behavior needs to be included in theory and clinical settings of nursing students. Exposure to ethical dilemmas through group activities and role play reminds nursing students of their role in these situations, as well as reinforces their obligations in such situations when they actually enter nursing practice. Once the Byrd's NEST is more developed and refined, the scenarios presented in this questionnaire could be used in nursing curricula as part of an ethics course or seminar to stimulate discussions surrounding nurses' ethical responsibilities in practice.

Implications for Nursing Research

The researcher has attempted to create an instrument for nurses to investigate and measure nurses' ethical sensitivity in practice. Creating an instrument for large samples of nurses will yield quantitative data that could reveal more insight into ethical sensitivity in nursing practice. Once a more refined instrument is developed, the Byrd's NEST will be able to advance the knowledge of ethics in nursing through a validation of ethical practice in nursing. By exposing nurses to situational ethical dilemmas, nurses can consider how they would respond in certain circumstances, which could offer a greater understanding of the virtues of nurses and thereby lead to providing more ethically sensitive, morally justifiable care.

The researcher's instrument and the instrument developed by Kim et al. both produced low internal consistency scores, and a score of 0.65 according to the Kuder-Richardson 20 value revealed the measure of reliability for the yes/no responses in Kim et al.'s study. The authors of this study advocated for developing sound instruments to assess ethical sensitivity of nurses in practice because this is critical to promote moral self-awareness. The conclusion these authors made was that ethical sensitivity is critical to ethical nursing practice and positive patient outcomes

Because of the scant amount of research on the ethical sensitivity of nurses in practice, more research needs to be conducted to validate nurses' ethical sensitivity. No other ethical sensitivity instruments in nursing have been found other than the Byrd's NEST and Kim et al.'s questionnaire, therefore the Byrd's NEST instrument needs to be further refined for measuring ethical sensitivity of

nurses in practice. Nurses, as a whole, first need to have a mindful and enriched sense of their ethical and moral values, and second they need to portray those values in practice and in the public's eyes.

Recommendations for Further Testing of the Instrument

The Byrd's NEST will be further reviewed, revised, and tested to improve the reliability and internal consistency of this instrument. Additional scenarios or different scenarios may be considered to reflect current trends and advances in healthcare arenas where new ethical dilemmas are created on a daily basis. More items will need to be added to increase the number of scenarios in the Byrd's NEST to 20 scenarios and to increase internal consistency once these items are refined. Two of the scenarios in the Byrd's NEST that were not based on nursing practice but rather personal dilemmas may be changed to reflect dilemmas in the practice settings.

Once the researcher has revised the Byrd's NEST, a new and different panel of nursing experts will be asked to evaluate the revised version of the Byrd's NEST for content validity. These expert nurses will be given the opportunity to select a fourth choice of action which they will have to write in. This will provide the researcher with alternative actions to be considered for inclusion as response choices in the instrument. Then, another small pilot study will be conducted with a different convenience sample of 20 nurses. Pilot studies will be conducted until the Byrd's NEST demonstrates internal consistency. Then an additional larger pilot study of 100 nurses, who did not complete the questionnaire for this dissertation, will be surveyed to evaluate the instrument's psychometric properties, including internal consistency and examine if there are correlations between the Byrd's

NEST and educational level of the nurse, years of nursing experience, if the nurse has attained specialty certification, work setting of the nurse, and if ethics education was included in the nurse's program of study.

After the instrument has been through this rigor, the research will then ask a new and different panel of experts to review the instrument to give feedback for content validity and readability. Once this process is completed, the Byrd's NEST could be administered to nurses and with nursing students to evaluate degree of ethical sensitivity in nursing practice.

Conclusion

As health professionals, nurses need to be sensitive to ethical issues and to manage ethical dilemmas effectively in clinical practice (Kim et al., 2005). For nurses to acquire skills necessary to navigate ethical dilemmas in practice, they must be exposed to such dilemmas, either in practice, in group discussions, or in surveys such as the Byrd's NEST, which facilitates the process of nurses evaluating their ethical sensitivity and ethical actions in such instances. There are instances where nurses are not adequately prepared to manage an ethical dilemma in practice because either they may not have been exposed to ways of managing such problems or they are not aware of their own ethical sensitivity and obligations to patients and families, or both. (Habel, 2005).

Ethics in nursing continues to be a vaguely understood aspect of nursing practice. Since nurses encounter ethical dilemmas on a daily basis, understanding ethics in nursing practice and the virtues of nursing could positively impact the nursing profession. The Byrd's NEST was created to assess the ethical sensitivity of nurses. Other than Kim et al.'s (2006) ethical sensitivity questionnaire, no

instruments are currently available to test ethics in nursing. The Byrd's NEST underwent a rigorous process in creation, testing, and evaluation but, at this stage of development, is not a reliable or valid instrument. Further testing of this instrument is a worthwhile endeavor as expert reviews and many of the participants in the different phases of development commented. The scenarios are realistic, they are actual dilemmas in nursing practice, and they make nurses consider what they would do in a certain situation.

There seems to have not been a willingness on the part of nurses to undertake the task of developing an instrument to assess nursing ethical sensitivity in practice because ethics has been a controversial topic in the healthcare arena and in the media, and ethics is a topic about which people feel uncomfortable in openly discussing. The situations in ethical dilemmas are not black and white issues but gray in that there is no true right or wrong in most situations and the choice of action may differ according to the person, context, and circumstances. But ethics and developing an instrument to assess nursing ethics is a very important topic because of the nature of nursing practice, a profession where nurses are obligated by the profession and by personal ethics to behave in an ethical manner.

Instrument development is a long and rigorous process but to develop a sound new instrument such as the Byrd's NEST, it must be put through multiple testing stages. As previously stated in this section of Chapter 5, expert reviewers had very positive comments about the Byrd's NEST instrument itself, and they expressed a critical need for an ethical sensitivity measurement in nursing. Some of the expert reviewers had constructive criticisms, which have been taken into

account and applied to improve the instrument. The Byrd's NEST is not completed in this stage of development.

The final version of the Byrd's NEST shown in this dissertation will be evaluated by another panel of nursing experts and further testing will be undertaken to continue the evaluation of the psychometric properties of this instrument so that a chance for better internal consistency and reliability can be documented. The instrument will be revised to make the two scenarios occurring outside the work setting scenarios within the context of a nurse's work setting. Additional scenarios will be added to increase the number of items to 20 scenarios to attempt to increase internal consistency. A different panel of nursing experts will evaluate the instrument for item construction, content validity, face validity, and clarity (or readability of questions). The expert nurses will also be allowed to add a fourth choice of action in which they will be required to write in their response. This action will allow the researcher to develop ideas for alternative action choices. The expert nurses will be asked to rank the response choices as high, medium, and low degrees of ethical sensitivity.

Next a pilot study will be conducted with a panel of 20 nurses to evaluate the instrument for internal consistency. Until the internal consistency reaches at least .60, the psychometric testing process will continue through pilot studies. Finally a larger pilot study will be undertaken with a sample of 100 nurses from the ANA membership list. An analysis of the instrument's for internal consistency will be conducted along with an analysis of correlations between the Byrd's NEST and: educational level of the nurse, years of nursing experience, if the nurse has

attained specialty certification, work setting of the nurse, and if ethics education was included in the nurse's program of study.

In this dissertation, this researcher intended to present the steps to instrument development by testing for psychometric properties of a newly developed instrument. The researcher accomplished this project and answered the five research questions. The steps of creation, testing, and evaluation were articulated in a logical and concise manner. The Byrd's NEST instrument itself is still in its infancy, and the testing and refinement process, as described in the previous section of Chapter 5, will continue because the researcher and the expert reviewers believe that this development is an important and worthwhile pursuit. After further testing and refinements are completed, the Byrd's NEST will be one of the two instruments thus far to assess ethical sensitivity in nursing practice. Once the instrument is able to reflect acceptable levels of internal consistency and reliability, it will be disseminated through presentation and publication.

APPENDIX A

Byrd's NEST-final version

Byrd's Nurse's Ethical Sensitivity Test (NEST)-Final Version

Please read the brief scenario and circle the answer that corresponds to the action that you would choose to do if put in this situation.

1) A 52 year old female has just been diagnosed with cancer but the doctor has ordered that the patient not be informed at the family's request. The patient is continuously asking about her condition and stating "I want to know if they have found something".

A	You talk to the patient, providing opportunities for her to discuss her thoughts and feelings about her condition and then discuss all possible diagnoses and offer options of treatment if it were cancer but refrain from telling the patient she has cancer.
B	You discuss her condition with her and inform her of the diagnosis of cancer. You stay with the patient to offer comfort and support.
C	You discuss the situation with the family and encourage them to tell her of the diagnosis of cancer. You place a call to the doctor to get permission to inform the patient, and offer to deliver the diagnosis if the family consents.

2) A 40 year old male patient who is an immigrant is being prepared to have surgery to treat lung cancer. The patient does not speak English but has signed the consent form. There is no family present. The patient nods yes to all questions but does not appear to understand what he is being asked. The nurse calls the surgery suite and the doctor to inform them that the consent is not valid. The doctor is infuriated and demands the patient be sent to surgery.

A	You refuse to send the patient to surgery and call for an interpreter.
B	You call the doctor, inform him of invalid consent, and page the nursing supervisor to deal with the situation.
C	You attempt to communicate with the patient, to inform to him that he is having lung surgery, and send him to surgery because the nurse knows it is in his best interest.

3) A 23 year old male comes into the clinic for a pre-employment physical examination. Included in the examination is a urine drug screen and HIV test for AIDS. The patient does not appear to be aware he is being tested for AIDS even though you have a signed consent form that he signed when he was signing all of his employment application paperwork. His HIV test comes back positive. Protocol is to send the results to the employer.

A	You notify the nurse practitioner or doctor at the clinic, send the results to the employer, and document the results in the chart.
B	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he then turns and walks out of the clinic.
C	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he turns to walk out but you redirect him to a vacant room and ask the nurse practitioner or doctor to discuss these findings with him.

4) A 95 year old female with a diagnosis of advanced dementia is a patient at an extended care facility in which you work. Several years ago, when she was more coherent, she stated repeatedly that she never wished to be kept alive by use of a feeding tube. Now she is unable to make decisions and has designated her niece as her surrogate decision maker. The niece consents to the insertion of a feeding tube placement and the patient is prepared to be sent for the procedure that afternoon.

A	You prepare the patient for the procedure because you understand that a feeding tube will provide for nutrition, fluids, and medications. This action is in the patient's best interest.
B	You attempt to contact the niece to relay information about the patient's wishes not to be kept alive by use of the feeding tube.
C	You notify the niece, the nursing supervisor, and the patient's doctor to relay the information that the patient did not wish to be kept alive by use of a feeding tube.

5) An 18 month old female is in the Pediatric Intensive Care Unit (PICU) under your care. She has suffered burns from a car accident. There is an emergency in the Emergency Room (ER) which requires your expertise and takes you away from your present duties. You are asked to go to the ER to assist. The child in PICU becomes extremely agitated when you leave her.

A	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.
B	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and then you call for someone else to assist in the ER and return to PICU.
C	You attempt to comfort the child in PICU first and then go to attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.

6) A middle aged man is in front of you at the hospital cafeteria and falls to the floor. You realize in your assessment that he has stopped breathing and does not have a pulse. You initiate Cardiopulmonary Resuscitation (CPR). A nurse from the code team arrives and tells you he will take over. You realize the nurse is incompetent and not performing CPR correctly.

A	You inform the nurse doing CPR you are also a nurse and that he is not performing CPR correctly. You resume CPR on the patient and tell the other nurse to call for backup assistance.
B	You inform the nurse doing CPR you are also a nurse and that he is not performing CPR correctly. You instruct him in the proper technique and stay until backup assistance arrives.
C	You inform the nurse doing CPR you are also a nurse and assist in 2-man CPR.

7) A 19 year old male is being admitted to the emergency room in extreme abdominal pain. When you palpate the RLQ, the patient hits you causing you to be slammed against the wall and fall to the floor. When you recover, you ask for another nurse to be assigned to his care. The other nurse who is assigned to care for him has gone to lunch and the patient is crying out in extreme pain, there are no other nurses available to assist in his care.

A	You attend the patient, evaluate his pain, and notify the nurse practitioner or doctor.
B	You attend to the patient and evaluate his pain. You document your observations and continue to monitor the patient.
C	You attend to the patient, evaluate his pain, and notify the nurse practitioner or doctor. You then call to get the test results, convey these results to the nurse practitioner or doctor.

8) A 25 year old female is being seen at your clinic for treatment of schizophrenia and resides at a personal care home. She also has a diagnosis of mental retardation and has developed to a mental age of about 4 years. The caregiver brought her in for an evaluation and the patient is presently becoming agitated because of paranoid delusions and having auditory hallucinations. The nurse prepares to give her an injection of antipsychotic medication when the patient becomes hysterical. The nurse is not able to give the injection and notifies the ordering practitioner. The practitioner tells you to give the injection to her no matter what it takes.

A	You attempt to talk to the patient at a level she will understand and persuades her to calm down. You then attempt to administer the shot with assistance of other office personnel but she becomes hysterical again. You then go back to the ordering practitioner.
B	You obtain assistance from other office personnel, enter the room, and talk to the patient. When she has calmed down, you tell her you are going to give her the injection, and administer the injection even though she starts to become hysterical when she sees the shot needle.
C	You obtain assistance from other office personnel and administer the injection. This medication is given in the patient's best interest and you know she would not understand even if you tried to explain it to her.

9) At the health department in which you are employed, a 16 year old mother brings her child to be seen because she is complaining of abdominal pain. Upon examining the 4 year old female child, you observe that she is very quiet and allows you to examine her without hesitation. You note that the hymen is not intact, there is swelling in the vaginal area, and you suspect sexual abuse. You convey your findings to the mother who seems annoyed by your accusation. (The 16 year old mother is the daughter of the doctor who staffs the clinic)

A	You document these findings, notify the head nurse of the clinic, and summon the police to file a report.
B	You document these findings, notify the doctor which is the child's grandfather, and ask for further orders.
C	You document these findings, notify the doctor which is the child's grandfather, and inform him that these findings will be reported and a police report will be filed. You allow the doctor to speak with the mother and child.

10) You are working the behavioral psychiatric unit and caring for a 16 year old girl who has attempted suicide. She has a visitor, another 16 year old girl, whom you overhear tell your patient that she is pregnant and that she heard her say that drinking alcohol, taking aspirin, and consuming anti-freeze will cause her to have an abortion. You know the mother of the pregnant teenage girl.

A	You call the mother of the pregnant teenage girl to inform her of what you heard because you know it is in the girl's best interest.
B	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You do not tell the girl's mother because this would be a breach of confidentiality.
C	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You then call the girl's mother to inform her of what you heard in order to protect her.

APPENDIX B

Moral Sensitivity Questionnaire (MSQ)

Lutzen, K., Everton, M., & Nordin, C. 1997

1. It is my responsibility as a psychiatrist to have knowledge of the patient's total situation.
2. My work would feel meaningless if I never saw any improvement in my patients.
3. It is important that I should obtain a positive response from the patient in everything I do.
4. When I need to make a decision against the will of a patient, I do so according to my opinion about what is good care.
5. If I should lose the patient's trust I would feel that my work would lack meaning.
6. When I have to make difficult decisions for the patient, it is important always to be honest with him or her.
7. I believe that good psychiatric care includes respecting the patient's self-choice.
8. If a patient does not have insight into the illness, there is little I can do for him or her.
9. I am often confronted by situations in which I experience conflict on how to approach the patient.
10. I believe that it is important to have firm principles for the care of certain patients.

11. I often face situations in which it is difficult to know what action is ethically right for a particular patient.
12. If I am acquainted with the case history of a patient, I follow the rules that are available.
13. What is most important in my psychiatric practice is my relationship with my patients.
14. I often face situations in which I have difficulty in allowing a patient to make his or her own decision.
15. I always base my actions on medical knowledge of what is the best treatment, even if the patient protests.
16. I think that good psychiatric care often includes making decisions for the patient.
17. I rely mostly on the nurse's knowledge about the patient when I am unsure.
18. Most of all, it is the reactions of patients that show me if I have made the right decisions.
19. I often think about my own values and norms that may influence my actions.
20. My own experience is more useful than theory in situations in which it is difficult to know what is ethically right.
21. It is important that I should have rules to follow when a patient who is not being treated under the Mental Health Act refuses treatment.
22. I believe that good psychiatric care includes patient participation, even of those with serious mental disorders.
23. I am often caught in predicaments where I have to make decisions without the patient's participation.

24. If a patient is being treated under the Mental Health Act, I expect nursing staff to follow my orders even if the patient is noncompliant.
25. I find it difficult to give good psychiatric care against the will of the patient.
26. Sometimes there are good reasons to threaten a patient with an injection if an oral medication is refused.
27. In situations in which it is difficult to know what is right, I consult my colleagues about what should be done.
28. I rely mostly on my own feelings when I have to make difficult decisions for a patient.
29. As a psychiatrist, I must always know how individual patients on my ward should be respectfully approached.
30. I find meaning in my role even if I do not succeed in helping a patient to gain insight into his or her illness.

The Anchors are:

1	2	3	4	5	6	7
Completely disagree				Completely agree		

APPENDIX C

Reidenbach & Robin's Items for Full and Short-Form (italicized) MES Versions

1. *Justice*

Just/Unjust

Fair/Unfair

Results/Does not result in an equal distribution of good and bad

2. *Relativist*

Culturally acceptable/Unacceptable

Individually acceptable/Unacceptable

Acceptable/Unacceptable to people I most admire

Traditionally acceptable/Unacceptable

Acceptable/Unacceptable to my family

3. *Egoism*

Self promoting/Not self promoting

Selfish/Not selfish

Self sacrificing/Not self sacrificing

Prudent/not prudent

Under no moral obligation/Morally obligate to act otherwise

Personally satisfying/Not personally satisfying

In the best interests of the company/Not in the best interests of the company

4. *Utilitarian*

Efficient/Inefficient

OK/Not OK if actions can be justified by their consequences

Compromises/Does not compromise an important rule by which I live

On balance, tends to be good/Bad

Produces the greatest/Least utility

Maximizes/Minimizes benefits while minimizes/maximizes harm

Leads to the greatest/Least good for the greatest number

Results in a positive/Negative cost-benefit ratio

Maximizes/Minimizes pleasure

5. *Deontology*

Violates/Does not violate an unwritten contract

Violates/Does not violate my ideas of fairness

Morally right/Not morally right

Obligated/Not obligated to act this way

Violates/Does not violate an unspoken promise

Duty bound to act this way/Not duty bound to act this way

Multidimensional Ethics Scale

Table 2. *Scenarios Used in Study*

Name (source) Low Intensity Control High Intensity Gifts (new) As a Media Buyer at an advertising agency, Nancy Brown negotiates the price of television airtime and then places buys on behalf of the agency's clients. The agency has a policy against employees accepting gifts from suppliers. Today a courier delivered a gift to Nancy from a salesperson at one of the TV stations. The gift is a paperback copy of a Michael

Crichton novel. Nancy has decided not to tell her boss about the gift, and plans on keeping it.

As a Media Buyer at an advertising agency, Nancy Brown negotiates the price of television airtime and then places buys on behalf of the agency's clients. The agency has a policy against employees accepting gifts from suppliers. Today a courier delivered a gift to Nancy from a salesperson at one of the TV stations. Nancy has decided not to tell her boss about the gift, and plans on keeping it.

As a Media Buyer at an advertising agency, Nancy Brown negotiates the price of television airtime and then places buys on behalf of the agency's clients. The agency has a policy against employees accepting gifts from suppliers. Today a courier delivered a gift to Nancy from a salesperson at one of the TV stations. The gift is a pair of one-carat diamond stud earrings. Nancy has decided not to tell her boss about the gift, and plans on keeping it.

Trade Show

(adapted from Dabholkar & Kellaris, 1992, p. 325)

While attending a trade show, K. Nagle passed by a competitor's exhibit, which was temporarily unattended. K. took the four remaining free product samples from the competitor's booth, brought them out behind the convention center, and threw them out. The competitor returned to the booth and discovered that all of the product samples were gone and no more were available for prospective buyers attending the show.

While attending a trade show, K. Nagle passed by a competitor's exhibit, which was temporarily unattended. K. took all of the remaining free product samples from the competitor's booth, brought them out behind the convention center, and threw them out. The competitor returned to the booth and discovered that all of the product samples were gone and no more were available for prospective buyers attending the show.

While attending a trade show, K. Nagle passed by a competitor's exhibit, which was temporarily unattended. K. took boxes with the remaining 500 free product samples from the competitor's booth, brought them out behind the convention center, and threw them out. The competitor returned to the booth and discovered that all of the product samples were gone and no more were available for prospective buyers

attending the show.

Office Supplies

(new)

Steve Atkins is the assistant in charge of ordering office supplies for a large accounting firm. In this week's shipment of supplies Steve discovered a box of staples that was not ordered, and that did not appear on the invoice. Steve decided not to tell the office supply company about the mistake and took the staples home. Steve Atkins is the assistant in charge of ordering office supplies for a large accounting firm. In this week's shipment of supplies Steve discovered an item that was not ordered, and that did not appear on the invoice. Steve decided not to tell the office supply company about the mistake and took the item home.

Steve Atkins is the assistant in charge of ordering office supplies for a large accounting firm. In this week's shipment of supplies Steve discovered a laptop computer that was not ordered, and that did not appear on the invoice. Steve decided not to tell the office supply company about the mistake and took the computer home.

New Market (adapted from Fritzsche Becker, 1984, p.169)

F. Connelly's firm is considering opening a facility in an underdeveloped country that appears to be poised for rapid growth in sales of consumer goods to the populace. Initial contacts with officials in the country left no doubt that approval of

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Multidimensional Ethics Scale

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the firm's entry into the market would require a contribution to the ruling political party. Other firms have also attempted to enter the market, some of which have made a contribution, and some of which have cancelled their plans because of their refusal to pay a contribution.

As CEO of the firm, F. has approved payment of the contribution. Market would require a contribution to the ruling political party. As CEO of the firm, F. has approved payment of the contribution. entry into the market would require a

contribution to the ruling political party. Every other firm that has attempted to enter the market has decided against it, because making a contribution was a business practice they did not wish to engage in.
As CEO of the firm, F. has approved payment of the contribution.

Lite Foods (adapted from Hoffman, 1998, p. 71)

Greg Vogel is the Marketing Director for a company that makes packaged foods that are relatively high in calories, which is hurting sales. Efforts to significantly reduce calories have adversely affected the taste. The government has regulations concerning the use of the word "light" in marketing food products. Industry practices vary greatly in the use of the word "lite" as a way to get around these regulations. Greg has decided to introduce a line of "lite" products that will contain only slightly fewer calories, but will be lighter in color, than the company's regular products.

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Greg Vogel is the Marketing Director for a company that makes packaged foods that are relatively high in calories, which is hurting sales. Efforts to significantly reduce calories have adversely affected the taste. The government has regulations concerning the use of the word "light" in marketing food products. The industry highly disapproves of the use of the word "lite" as a way to get around these regulations. Greg has decided to introduce a line of "lite" products that will contain only slightly fewer calories, but will be lighter in color, than the company's regular products.

Computer Software (new)

Meg Dempsey decided to buy a new computer. She was able to purchase a state-of-the-art computer at a very affordable price, but the trade-off for getting a low price was that it came with a very limited amount of pre-loaded software. While her co-workers have mixed opinions about using unlicensed software, Meg has decided to install software, licensed exclusively to her workplace, onto her home computer for personal use.

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Meg Dempsey decided to buy a new computer. She was able to purchase a state-of-the-art computer at a very affordable price, but the trade-off for getting a low price was that it came with a very limited amount of pre-loaded software. Even though her co-workers strongly support the purchase of a separate license for every computer on which a piece of software will be loaded, Meg has decided to install software, licensed exclusively to her workplace, onto her home computer for personal use.

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Delivery Date

(adapted from Reidenbach, Robin, & Dawson, 1991, p. 85)

Nearing the end of the month, Wayne Hall, a salesperson for a wholesale garden supply company, saw that he was just short of making his monthly sales budget. Wayne's commission rate on all of his monthly sales is higher if he exceeds his budget. In order to close a sale that would put him over his goal, Wayne promised a client a delivery date that his factory has a 10% chance of not being able to meet. Nearing the end of the month, Wayne Hall, a salesperson for a wholesale garden supply company, saw that he was just short of making his monthly sales budget. Wayne's commission rate on all of his monthly sales is higher if he exceeds his budget. In order to close a sale that would put him over his goal, Wayne promised a client a delivery date that he is unsure his factory will be able to meet.

Nearing the end of the month, Wayne Hall, a salesperson for a wholesale garden supply company, saw that he was just short of making his monthly sales budget. Wayne's commission rate on all of his monthly sales is higher if he exceeds his budget. In order to close a sale that would put him over his goal, Wayne promised a client a delivery date that his factory has a 90% chance of not being able to meet.

Christmas Toy

(adapted from Dawson, 1995, p. 62)

C. Kemp is the manager of a local toy store. The hottest Christmas toy of the year is the new "Peter Panda" stuffed animal, which is in great demand, and almost impossible to find. The store recently received a shipment of 12 "Peter Pandas", all of which are promised to people who previously stopped in the store to place a deposit to reserve one. The manufacturer has assured C. that the store will get another shipment before Christmas. C. decided to personally purchase one of the twelve as a Christmas present for a friend's child.

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Engine

Control Settings

(adapted from Zych, 1999, p. 258)

Laura Elkins has been notified that some of the used cars she is selling were manufactured with incorrect engine control settings. The error will not be noticed by most of her customers since it does not affect the performance of the cars. However, the error can create emissions levels that are higher than those allowed by environmental regulations, which may be detected during state emissions inspection programs. The error only impacts emissions under extremely high temperature conditions, and the dealership is located in Alaska. Laura has decided not to tell her buyers of the problem.

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Waste Disposal Amy Mullins is the President of a medium- Amy Mullins is the President of a medium- Amy Mullins is the President of a medium

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(adapted from McCabe, Dukerich & Dutton, 1991, p.954)

A sized medical waste disposal company. A recent internal study conducted by the company has uncovered evidence that certain materials disposed of by the firm may pose an environmental hazard to some sensitive wetlands. The report states that negative effects on the wetlands will not occur for another 20 years. Amy has decided to allow the current disposal procedure to continue.

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Retirement

Benefits (adapted from Jones, 1991, p. 376)\

P. Turner is the Chief Executive Officer for an airline that has been going through rough financial times in recent years. P. had the finance department run the numbers on a variety of ways to cut overhead expenses, after which they made three recommendations. P. has chosen the recommendation to cut employee retirement benefits, a plan which will be phased in over the next 20 years.

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Undercoating

(adapted from Zych, 1999, p. 258)

Bob Gibson, the owner of an automobile dealership, has just become aware of a problem with the finish on one of the current model cars, which is not covered under the car's warranty. The Department of Public Works is using a type of road salt that may cause the paint under the car to start to blister after 15 years of exposure to the salt. Because of the location on the car, the chipping will not be readily visible. Bob decides not to tell his customers.

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Housing Development (adapted from
Fritzsche, 1995, p. 913)

Ed Worley recently purchased a large tract of land in an undeveloped country for a new housing development his firm is about to start building. After making the purchase he discovered that the land is in an area that has flooded in the past. Ed has decided to proceed with the housing development anyway.

Ed Worley recently purchased a large tract of land for a new housing development his firm is about to start building. After making the purchase he discovered that the land is in an area that has flooded in the past. Ed has decided to proceed with the housing

development anyway. Ed Worley recently purchased a large tract of land in his home town for a new housing development his firm is about to start building. After making the purchase he discovered that the land is in an area that has flooded in the past. Ed has decided to proceed with the housing development anyway.

Multidimensional Ethics Scale

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(adapted from Harris, 1990, p. 748)

Sleepwear T. Smith is the Chief Operating Officer of T. Smith is the Chief Operating Officer of a T. Smith is the Chief Operating Officer of a manufacturer of children's sleepwear. The company responded to an appeal by the National Safety Commission and treated its entire fall line with the flame retardant agent TRIS. Research has since found TRIS to be a carcinogenic agent. T. has approved the sale of the entire lot of unsold inventory to a third-world country. manufacturer of children's sleepwear. The company responded to an appeal by the National Safety Commission and treated its entire fall line with the flame retardant agent TRIS. Research has since found TRIS to be a carcinogenic agent. T. has approved the sale of the entire lot of unsold inventory. manufacturer of children's sleepwear. The company responded to an appeal by the National Safety Commission and treated its entire fall line with the flame retardant agent TRIS. Research has since found TRIS to be a carcinogenic agent. T. has approved the sale of the entire lot of unsold inventory to a retail store in town.

Used Car

(adapted from Reidenbach, Robin, & Dawson, 1991, p. 85)

Hannah Rollins recently purchased a new car. While she originally desired to trade in her old car at the dealership where she bought her new car, a serious engine problem was detected when the car was being appraised, so the price the dealership offered was quite low. Hannah decided that she could get a higher price if she sold it on her own, so she placed an ad in the paper. When a buyer from out-of-state came to look at her car, Hannah decided not to mention the engine problem.

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Warranty

(adapted from Jones, 1991, p. 377)

David Fleming is a Claims Adjuster for a company that manufactures roofing materials. The company is aware of a defect in roofing tiles that they manufactured over the past year. The wording of the warranty on the tiles is vague enough to provide a loophole by which David may deny warranty coverage to customers. Currently there are \$100,000 in outstanding warranty claims regarding the defective roofing tiles, filed by 10,000 individual homeowners with a claim of \$10.00 each. David has decided to use the loophole to deny coverage on all of the outstanding claims.

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Cutting Expenses (new)

Regan Preston is the Production Manager for a company that manufactures gift bags.

Sales have been weaker than expected, and Regan has been told to review her department's budget and find some way to cut expenses. Regan Preston is the Production Manager for a company that manufactures gift bags. Sales have been weaker than expected, and

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Regan Preston is the Production Manager for a company that manufactures gift bags. Sales have been weaker than expected, and Regan has been told to review her department's budget and find some way to cut \$40,000 in expenses over the next four months.

Regan has decided to temporarily cut 100 employees' salaries by \$400 each (\$100 per month for four months). expenses over the next four months.

Regan has decided to temporarily cut \$40,000 from employee salaries. cut \$40,000 in expenses over the next four months.

Regan has decided to temporarily cut five of her employees' salaries by \$8,000 each (\$2,000 per month for four months).

Product

Shortage (new)

J. Lambert is the Shipping Supervisor for a company with the exclusive U.S. distribution contract for a product manufacture overseas. Due to a strike at the factory, orders have been unfulfilled for the past 6 months. Recently the strike ended, and today a shipment arrived with exactly enough units to fulfill the backorders. Due to supply and demand, prices have gone up since the backorders were placed. J. has decided to short-ship the backorders of one hundred customers by 200 units each in order to keep 200,000 units on the shelf for future orders at the higher price.

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APPENDIX D

Byrd's NEST P-1

Please read the brief scenario and circle the answer that corresponds to the action that you would choose to do if put in this situation.

1) A 52 year old female has just been diagnosed with cancer but the doctor has ordered that the patient not be informed. Although the family is aware, they wish the doctor not to inform the patient of the diagnosis. The patient is continuously asking about her condition and stating "I want to know if they have found something".

A	The nurse talks to the patient, allowing her to discuss her feelings and emotions about her condition. The nurse discusses all possible diagnoses, offers options of treatment if it were cancer, but refrains from telling her she has cancer.
B	The nurse discusses her condition with her and informs her of the diagnosis of cancer. The nurse stays with the patient to offer comfort and allow her to ventilate her feelings.
C	The nurse discusses the situation with the family and encourages them to tell her of the diagnosis of cancer, places a call to the doctor to get permission to inform the patient, and offers to deliver the diagnosis if the family consents.

2) A 40 year old male patient who is an immigrant is being prepared to have surgery to treat lung cancer. The patient does not speak English but has signed the consent form. There is no family present. The patient nods yes to all questions but does not appear to understand what he is being asked. The nurse calls the surgery suite and the doctor to inform them that the consent is not valid. The doctor is infuriated and demands the patient be sent to surgery.

A	The nurse refuses to send the patient to surgery and calls for an interpreter. The interpreter is delayed for 2 hours and the surgery is cancelled for the day. The doctor reports the nurse to administration for insubordination.
B	The nurse calls the doctor, informs him of invalid consent, and pages the nursing supervisor to deal with the situation.
C	The nurse attempts to communicate with the patient, attempting to inform to him that he is having lung surgery, and sends him to surgery because the nurse knows it is in his best interests.

3) As the buyer for the surgery department, the nurse negotiates the price of a Laser Surgical System and then places the order on the hospital's behalf. The hospital has a policy against employees accepting gifts from suppliers. Today a courier delivered a popular best selling novel to the nurse from the salesperson.

A	The nurse accepts the gift and does not tell her superior.
B	The nurse refuses the gift and sends it back to the sender by the courier.
C	The nurse discusses the matter with her superior and plans to return the book if her superior feels it is inappropriate.

4) A 23 year old male comes into the clinic for a pre-employment physical examination. Included in the examination is a urine drug screen and HIV test for AIDS. The patient is not aware he is being tested for AIDS. His test comes back positive. Protocol is to send the results to the employer.

A	The nurse notifies the nurse practitioner or doctor at the clinic, send the results to the employer, and documents this was done in the chart.
B	The nurse places a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he then turns and walks out.
C	The nurse places a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he turns to walk out but the nurse redirects him to a vacant room and informs him of his diagnosis. The nurse offers comfort and referrals for treatment.

5) A 95 year old female with a diagnosis of advanced dementia is a patient at an extended care facility in which you work. Several years ago, when she was more coherent, she stated repeatedly that she never wished to be kept alive by use of a feeding tube. Now she is unable to make decisions and has her niece as her surrogate decision maker. The niece consents to a feeding tube placement and the patient is prepared to be sent for the procedure.

A	The nurse prepares the patient for the procedure because a feeding tube will allow for nutrition, fluids, and medications. This is in the patient's best interest.
B	The nurse attempts to contact the niece to relay information about the patient's wishes not to be kept alive by use of a feeding tube.
C	The nurse notifies the nursing supervisor and the patient's doctor to relay the information that the patient did not wish to be kept alive by use of a feeding tube.

6) A nurse who is pursuing a Master's degree in nursing has decided to buy a new computer to assist her in her studies. The nurse was able to purchase a state-of-the-art computer at a very affordable price but the trade off for getting a low price was that it came with a very limited amount of pre-loaded software. The nurse works at a local University Hospital and has access to the computer system. While the nurse's co-workers have mixed opinions about using unlicensed software, the nurse has decided to install software, licensed exclusively to her workplace, onto her home computer for personal use. The co-workers are aware that the nurse has illegally installed this software.

A	Co-workers should discuss the matter with their superior.
B	Co-workers should say nothing; if caught, the nurse will have to deal with the consequences.
C	Co-workers should report the nurse to the software company.

7) An 18 month old female is in the Pediatric Intensive Care Unit (PICU) under your care. She has suffered burns from a car accident. There is an emergency in the PICU which requires your expertise. The child becomes extremely agitated when you leave her since it is the end of your shift.

A	The nurse calls for another nurse to comfort the child and attends to the other patient's emergency situation since you have the most expertise for this particular situation. The child is not consoled by the other nurse and must be sedated with medication.
B	The nurse calls for another nurse to comfort the child and attends to the emergency with the other patient but realizes the child is not being consoled. The nurse then calls for someone else to assist in the emergency and returns to console the child.
C	The nurse attempts to comfort the child first and then goes to attend to the emergency with the other patient.

8) A 40 year old male is front of you at the grocery store and falls to the floor. You realize in your assessment that he has stopped breathing and does not have a pulse. You initiate Cardiopulmonary Resuscitation (CPR). An ambulance arrives and a paramedic tells you he will take over. You realize the paramedic is incompetent and not performing CPR correctly.

A	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You resume CPR on the patient and tell the paramedic to call for backup assistance.
B	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You instruct him in the proper technique and stay until backup assistance arrives.
C	You inform the paramedic you are a nurse and assist in 2-man CPR.

9) A nurse works at a community clinic where the flu vaccine is in short supply this year and almost impossible to find. The clinic recently received a shipment of 50 vaccine doses, all of which are promised to people who previously stopped by the clinic to get the vaccine shot and were placed on a waiting list. The manufacturer of the vaccine assured the clinic that it would receive another shipment soon. The nurse decided to call their spouse to come in for a flu vaccine shot before calling those on the waiting list. You work in the same clinic with this nurse.

A	You should say nothing.
B	You should talk to the nurse about this matter.
C	You should talk to your supervisor about this matter.

10) A 19 year old male is being admitted to the emergency room in extreme abdominal pain. When you palpate the RLQ, the patient hits you causing you to hit the wall and fall to the floor. When you recover, you ask for another nurse to be assigned to his care. The other nurse who is assigned to care for him has gone to lunch and the patient is crying out in extreme pain, there are no other nurses available to assist in his care.

A	You attend the patient, evaluate his pain, and call the nurse practitioner or doctor to see if it is appropriate to give him pain medication.
B	You attend to the patient and evaluate his pain. There is no pain medication ordered because the nurse practitioner and doctor are waiting on test results. You document your observations and continue to monitor the patient.
C	You attend to the patient, evaluate his pain, and notify the nurse practitioner or doctor of the complaints of pain but no medication is ordered because they are waiting on test results. You then call to get the test results, convey these results to the nurse practitioner or doctor, and continue to seek pain medication even though the patient has now become belligerent.

11) A 25 year old female is being seen at your clinic for treatment of schizophrenia and is presently having paranoid delusions and having hallucinations. She also has a diagnosis of mental retardation and has developed to a mental age of 4. The nurse prepares to give her an injection of antipsychotic medication when the patient becomes hysterical. The nurse is not able to give the injection and notifies the ordering practitioner. The practitioner tells you to give it to her no matter what it takes.

A	The nurse attempt to talk to the patient at a level she will understand and persuades her to calm down. The nurse attempts to administer the shot with assistance of other office personnel but she becomes hysterical again. The nurse then goes back to the ordering practitioner.
B	The nurse obtains assistance from other office personnel, enters the room, and talks to the patient. When she has calmed down, you tell her you are going to give her the injection, and administer the injection even though she starts to become hysterical when she sees the shot needle. This task has taken one hour to perform, causing a great delay in your busy clinic.
C	The nurse obtains assistance from other office personnel and administers the injection. This is done in the patient's best interest and you know she would not understand even if you tried to explain it to her. The patient eventually calms down.

12) The nurse manager of a unit which cares for cancer patients also administers chemotherapy and has patients who have received radioactive treatments. Some of the patients have catheters which contain urine that is radioactive. The unit is short staffed and has pulled an aide from another unit to assist in taking vital signs and empty the catheter bags. The aide is 10 weeks pregnant.

A	Even though you are very busy, you offer to empty the bags for the aide knowing that this will make you have to stay after your shift to finish your work.
B	You inform the aide of the radioactive urine and advise her to avoid emptying these bags.
C	You say nothing, knowing that the exposure to radioactivity is low and, since it will only be this one shift, should not cause any harm to the aide or her developing fetus.

13) At the health department in which you are employed, a 16 year old mother brings her child to be seen because she is complaining of abdominal pain. Upon examining the 4 year old female child, you observe that she is very quiet and allows you to examine her without hesitation. You note that the hymen is not intact, there is swelling in the vaginal area, and you suspect sexual abuse. You convey your findings to the mother who seems annoyed by your accusation. (The 16 year old mother is the daughter of the doctor who staffs the clinic)

A	The nurse documents these findings, notifies the head nurse of the clinic, and summons the police to file a report. This is extremely upsetting to the doctor-the child's grandfather.
B	The nurse documents these findings, notifies the doctor-the child's grandfather, and asks the doctor for further orders.
C	The nurse documents these findings, notifies the doctor-the child's grandfather, and informs him that these findings will be reported and a police report will be filed. The nurse allows the doctor to speak with the mother and child. The mother becomes extremely upset and is very uncooperative when the nurse has the police come to investigate.

14) You are shopping when you overhear one female teenager tell another (who is pregnant) that drinking alcohol, taking aspirin, and consuming anti-freeze will cause her to have an abortion. You know the mother of the pregnant teenager.

A	You call the mother of the pregnant teenager to inform her of what you heard because you know it is in the girl's best interest.
B	You stop and talk to the pregnant teenager. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You do not tell the teenager's mother because this would be a breach of confidentiality.
C	You stop and talk to the pregnant teenager. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You then call the teenager's mother to inform her of what you heard in order to protect the girl.

15) You are the surgical nurse circulating at a surgery for a patient undergoing the removal of an ovarian cyst; the patient has a diagnosis of AIDS. The surgeon performs the cyst removal and begins to perform a tubal ligation (which there is no consent to perform). The surgical nurse informs the surgeon that the consent does not state tubal ligation will be performed. The surgeon comments that patient has AIDS and indicated to the surgeon that she wanted a tubal ligation and the surgeon must have forgotten to put it on the consent form.

A	You tell the surgeon to stop the surgery and notify the nurse manager of surgery of the situation.
B	You allow the operation to proceed and notify the nurse manager of surgery of the situation.
C	You tell the surgeon to stop the tubal ligation, notify the nurse manager of surgery of the situation, and tell the patient about the situation after she wakes from anesthesia.

APPENDIX E

MSQ items (adapted for this study)

Lutzen, Nordin, & Everton, 1997

Please indicate your level of agreement or disagreement to the statements regarding your nursing practice.

1. It is my responsibility as a nurse to have knowledge of the patient's total situation.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
2. It is important that I should obtain a positive response from the patient in everything I do.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
3. I believe that good nursing care includes respecting a patient's self choice.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
4. If I am unacquainted with the case history of a patient, I follow the rules that are available.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
5. I often face situations in which I have difficulty in allowing a patient to make his or her own decision.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
6. I always base my actions on medical knowledge of what is best treatment, even if the patient protests.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
7. My own experience is more useful than theory in situations in which are difficult to know what is ethically right.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
8. In situations in which it is difficult to know what is right, I consult my colleagues' opinions to help make my decision about the best choice of action.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
9. When I need to make a decision against the will of a patient, I do so according to my opinion about what is good care.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree
10. I rely mostly on my colleagues' (other nurses) knowledge about a patient when I am unclear about the situation at hand.	Completely Agree	Somewhat Agree	Agree	Somewhat Disagree	Completely Disagree

APPENDIX F

MES items (adapted for this study)

Reidenbach & Robin, 1990

Scenarios adapted from the Multidimensional Ethics Scale

1) You are the nurse who is the buyer for the surgery department and you negotiate the price of a Laser Surgical System, placing the order on the hospital's behalf. The hospital has a policy against employees accepting gifts from suppliers. Today a courier delivered a popular best selling novel to you from the salesperson.

A	You accept the gift and do not tell her superior.
B	You refuse the gift and send it back to the sender by the courier.
C	You discuss the matter with your superior and plan to return the book if your superior feels it is inappropriate.

*adapted from MES scenario about the Media Buyer, Nancy Brown, accepting gifts from distributors

2) A nurse who is pursuing a Master's degree in nursing has decided to buy a new computer to assist in these studies. This nurse was able to purchase a state-of-the-art computer at a very affordable price but the trade off for getting a low price was that it came with a very limited amount of pre-loaded software. The nurse works at a local University Hospital and has access to the computer system. You are a co-worker of this nurse and many of other co-workers have mixed opinions about using unlicensed software but this nurse has decided to install software, licensed exclusively to her workplace, onto this new computer for personal use.

A	You should discuss the matter with their superior.
B	You should say nothing; if caught, the nurse will have to deal with the consequences.
C	You should report the nurse to the software company.

*adapted from MES scenario about stealing computer software, Meg Dempsey;

3) A nurse works at a community clinic where this year's flu vaccine is in short supply nationally and almost impossible to find locally. The clinic recently received a shipment of 50 vaccine doses, all of which are promised to people who previously stopped by the clinic to get their flu vaccine and were placed on a waiting list. The manufacturer of the vaccine assured the clinic manager that the clinic would receive another shipment soon. Another nurse in the clinic decided to call their spouse to come in for the flu vaccine before calling those on the waiting list. You work in the same clinic with this nurse.

A	You should say nothing.
B	You should talk to the nurse about this matter.
C	You should talk to your supervisor about this matter.

*adapted from MES scenario about product shortage, C. Kemp giving a Christmas toy (hot item in short supply) to family members before those on waiting list

4) The nurse manager of a unit which cares for cancer patients receiving chemotherapy and radioactive treatments. Some of the patients have indwelling catheters which contain urine that is radioactive. The unit is short staffed and has pulled an aide from another unit to assist in taking vital signs and emptying the catheter bags. The aide is 10 weeks pregnant.

A	You offer to empty the bags for the aide knowing that performing these tasks will make you have to stay after your shift to finish your work.
B	You inform the aide of the radioactive urine and advise her to avoid emptying these bags.
C	You say nothing, knowing that the exposure to radioactivity is low and, since it will only be this one shift, should not cause any harm to the aide or her developing fetus.

*adapted from MES scenario about inappropriate medical waste disposal

5) You are the surgical nurse circulating at a surgery for a patient undergoing the removal of an ovarian cyst; the patient has a diagnosis of AIDS. The surgeon performs the cyst removal and begins to perform a tubal ligation (for which there is no consent to perform). You inform the surgeon that the consent does not state that a tubal ligation will be performed. The surgeon comments that patient has AIDS and indicated to the surgeon that she wanted a tubal ligation and the surgeon must have forgotten to put it on the consent form.

A	You tell the surgeon to stop the tubal ligation and notify the nurse manager of surgery of the situation.
B	You allow the operation to proceed and notify the nurse manager of surgery of the situation.
C	You tell the surgeon to stop the tubal ligation, notify the nurse manager of surgery of the situation, and tell the patient about the situation after she wakes from anesthesia.

*adapted from MES scenario about control settings being changed without permission, Laura Ekins.

APPENDIX G

Byrd's NEST P-2: includes Byrd's NEST scenarios and MES scenarios

Please read the brief scenario and circle the answer that corresponds to the action that you would choose to do if put in this situation.

1) A 52 year old female has just been diagnosed with cancer but the doctor has ordered that the patient not be informed. Although the family is aware, they wish the doctor not to inform the patient of the diagnosis. The patient is continuously asking about her condition and stating "I want to know if they have found something".

A	The nurse talks to the patient, providing opportunities for her to discuss her thoughts and feelings about her condition. The nurse discusses all possible diagnoses, offers options of treatment if it were cancer, but refrains from telling her she has cancer.
B	The nurse discusses her condition with her and informs her of the diagnosis of cancer. The nurse stays with the patient to offer comfort and support.
C	The nurse discusses the situation with the family and encourages them to tell her of the diagnosis of cancer, places a call to the doctor to get permission to inform the patient, and offers to deliver the diagnosis if the family consents.

2) A 40 year old male patient who is an immigrant is being prepared to have surgery to treat lung cancer. The patient does not speak English but has signed the consent form. There is no family present. The patient nods yes to all questions but does not appear to understand what he is being asked. The nurse calls the surgery suite and the doctor to inform them that the consent is not valid. The doctor is infuriated and demands the patient be sent to surgery.

A	The nurse refuses to send the patient to surgery and calls for an interpreter. The interpreter is delayed for 2 hours and the surgery is cancelled for the day and the doctor reports the nurse to administration for insubordination.
B	The nurse calls the doctor, informs him of invalid consent, and pages the nursing supervisor to deal with the situation.
C	The nurse attempts to communicate with the patient, attempting to inform to him that he is having lung surgery, and sends him to surgery because the nurse knows it is in his best interests.

3) As the buyer for the surgery department, the nurse negotiates the price of a Laser Surgical System and then places the order on the hospital's behalf. The hospital has a policy against employees accepting gifts from suppliers. Today a courier delivered a popular best selling novel to the nurse from the salesperson.

A	The nurse accepts the gift and does not tell her superior.
B	The nurse refuses the gift and sends it back to the sender by the courier.
C	The nurse discusses the matter with her superior and plans to return the book if her superior feels it is inappropriate.

4) A 23 year old male comes into the clinic for a pre-employment physical examination. Included in the examination is a urine drug screen and HIV test for AIDS. The patient is not aware he is being tested for AIDS. His test comes back positive. Protocol is to send the results to the employer.

A	The nurse notifies the nurse practitioner or doctor at the clinic, sends the results to the employer, and documents the results in the chart.
B	The nurse places a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he then turns and walks out of the clinic.
C	The nurse places a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he turns to walk out but the nurse redirects him to a vacant room and informs him of his diagnosis.

5) A 95 year old female with a diagnosis of advanced dementia is a patient at an extended care facility in which you work. Several years ago, when she was more coherent, she stated repeatedly that she never wished to be kept alive by use of a feeding tube. Now she is unable to make decisions and has her niece as her surrogate decision maker. The niece consents to the insertion of a feeding tube placement and the patient is prepared to be sent for the procedure that afternoon.

A	The nurse prepares the patient for the procedure because a feeding tube will provide for nutrition, fluids, and medications. This action is in the patient's best interest.
B	The nurse attempts to contact the niece to relay information about the patient's wishes not to be kept alive by use of the feeding tube.
C	The nurse notifies the niece, the nursing supervisor, and the patient's doctor to relay the information that the patient did not wish to be kept alive by use of a feeding tube.

6) A nurse who is pursuing a Master's degree in nursing has decided to buy a new computer to assist her in her studies. The nurse was able to purchase a state-of-the-art computer at a very affordable price but the trade off for getting a low price was that it came with a very limited amount of pre-loaded software. The nurse works at a local University Hospital and has access to the computer system. While the nurse's co-workers have mixed opinions about using unlicensed software, the nurse has decided to install software, licensed exclusively to her workplace, onto her home computer for personal use. The co-workers are aware that the nurse has illegally installed this software.

A	Co-workers should discuss the matter with their superior.
B	Co-workers should say nothing; if caught, the nurse will have to deal with the consequences.
C	Co-workers should report the nurse to the software company.

7) An 18 month old female is in the Pediatric Intensive Care Unit (PICU) under your care. She has suffered burns from a car accident. There is an emergency in the Emergency Room (ER) which requires your expertise and takes you away from your present duties. You are asked to go to the ER to assist. The child in PICU becomes extremely agitated when you leave her.

A	You call for another nurse to comfort the child in PICU and attend to the patient in the ER since you have the most expertise for this particular situation. The child in PICU is not consoled by the other nurse and must be sedated with medication.
B	You call for another nurse to comfort the child in PICU and attend to the patient in the ER but realize the child in PICU is not being consoled. You then call for someone else to assist in the ER and return to PICU.
C	You attempt to comfort the child in PICU first and then go to attend to the patient in the ER.

8) A middle aged man is in front of you at the grocery store and falls to the floor. You realize in your assessment that he has stopped breathing and does not have a pulse. You initiate Cardiopulmonary Resuscitation (CPR). An ambulance arrives and a paramedic tells you he will take over. You realize the paramedic is incompetent and not performing CPR correctly.

A	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You resume CPR on the patient and tell the paramedic to call for backup assistance.
B	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You instruct him in the proper technique and stay until backup assistance arrives.
C	You inform the paramedic you are a nurse and assist in 2-man CPR.

9) A nurse works at a community clinic where this year's flu vaccine is in short supply nationally and almost impossible to find locally. The clinic recently received a shipment of 50 vaccine doses, all of which are promised to people who previously stopped by the clinic to get their flu vaccine and were placed on a waiting list. The manufacturer of the vaccine assured the clinic manager that the clinic would receive another shipment soon. Another nurse in the clinic decided to call their spouse to come in for the flu vaccine before calling those on the waiting list. You work in the same clinic with this nurse.

A	You should say nothing.
B	You should talk to the nurse about this matter.
C	You should talk to your supervisor about this matter.

10) A 19 year old male is being admitted to the emergency room in extreme abdominal pain. When you palpate the RLQ, the patient hits you causing you to be slammed against the wall and fall to the floor. When you recover, you ask for another nurse to be assigned to his care. The other nurse who is assigned to care for him has gone to lunch and the patient is crying out in extreme pain, there are no other nurses available to assist in his care.

A	You attend the patient, evaluate his pain, and call the nurse practitioner or doctor to see if it is appropriate to give him pain medication.
B	You attend to the patient and evaluate his pain. There is no pain medication ordered because the nurse practitioner and doctor are waiting on test results. You document your observations and continue to monitor the patient.
C	You attend to the patient, evaluate his pain, and notify the nurse practitioner or doctor of the complaints of pain but no medication is ordered because they are waiting on test results. You then call to get the test results, convey these results to the nurse practitioner or doctor.

11) A 25 year old female is being seen at your clinic for treatment of schizophrenia and is presently is becoming agitated because of paranoid delusions and having auditory hallucinations. She also has a diagnosis of mental retardation and has developed to a mental age of about 4 years. The nurse prepares to give her an injection of antipsychotic medication when the patient becomes hysterical. The nurse is not able to give the injection and notifies the ordering practitioner. The practitioner tells you to give the injection to her no matter what it takes.

A	The nurse attempt to talk to the patient at a level she will understand and persuades her to calm down. The nurse attempts to administer the shot with assistance of other office personnel but she becomes hysterical again. The nurse then goes back to the ordering practitioner.
B	The nurse obtains assistance from other office personnel, enters the room, and talks to the patient. When she has calmed down, you tell her you are going to give her the injection, and administer the injection even though she starts to become hysterical when she sees the shot needle.
C	The nurse obtains assistance from other office personnel and administers the injection. This medication is given in the patient's best interest and you know she would not understand even if you tried to explain it to her.

12) The nurse manager of a unit which cares for cancer patients receiving chemotherapy and radioactive treatments. Some of the patients have indwelling catheters which contain urine that is radioactive. The unit is short staffed and has pulled an aide from another unit to assist in taking vital signs and emptying the catheter bags. The aide is 10 weeks pregnant.

A	Even though you are very busy, you offer to empty the bags for the aide knowing that these tasks will make you have to stay after your shift to finish your work.
B	You inform the aide of the radioactive urine and advise her to avoid emptying these bags.
C	You say nothing, knowing that the exposure to radioactivity is low and, since it will only be this one shift, should not cause any harm to the aide or her developing fetus.

13) At the health department in which you are employed, a 16 year old mother brings her child to be seen because she is complaining of abdominal pain. Upon examining the 4 year old female child, you observe that she is very quiet and allows you to examine her without hesitation. You note that the hymen is not intact, there is swelling in the vaginal area, and you suspect sexual abuse. You convey your findings to the mother who seems annoyed by your accusation. (The 16 year old mother is the daughter of the doctor who staffs the clinic)

A	The nurse documents these findings, notifies the head nurse of the clinic, and summons the police to file a report.
B	The nurse documents these findings, notifies the doctor which is the child's grandfather, and asks for further orders.
C	The nurse documents these findings, notifies the doctor which is the child's grandfather, and informs him that these findings will be reported and a police report will be filed. The nurse allows the doctor to speak with the mother and child.

14) You are shopping when you overhear two very young girls talking. One girl tells the other girl (who is pregnant) that drinking alcohol, taking aspirin, and consuming anti-freeze will cause her to have an abortion. You know the mother of the pregnant teenage girl.

A	You call the mother of the pregnant teenage girl to inform her of what you heard because you know it is in the girl's best interest.
B	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You do not tell the girl's mother because this would be a breach of confidentiality.
C	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You then call the girl's mother to inform her of what you heard in order to protect her.

15) You are the surgical nurse circulating at a surgery for a patient undergoing the removal of an ovarian cyst; the patient has a diagnosis of AIDS. The surgeon performs the cyst removal and begins to perform a tubal ligation (for which there is no consent to perform). You inform the surgeon that the consent does not state that a tubal ligation will be performed. The surgeon comments that patient has AIDS and indicated to the surgeon that she wanted a tubal ligation and the surgeon must have forgotten to put it on the consent form.

A	You tell the surgeon to stop the surgery and notify the nurse manager of surgery of the situation.
B	You allow the operation to proceed and notify the nurse manager of surgery of the situation.
C	You tell the surgeon to stop the tubal ligation, notify the nurse manager of surgery of the situation, and tell the patient about the situation after she wakes from anesthesia.

APPENDIX H

Byrd's NEST P-3: includes Byrd's NEST scenarios and MES scenarios

Please read the brief scenario and circle the answer that corresponds to the action that you would choose to do if put in this situation.

1) A 52 year old female has just been diagnosed with cancer but the doctor has ordered that the patient not be informed. The doctor does not to inform the patient of the diagnosis at the family's request. The patient is continuously asking about her condition and stating "I want to know if they have found something".

A	You talk to the patient, providing opportunities for her to discuss her thoughts and feelings about her condition and then discuss all possible diagnoses and offer options of treatment if it were cancer but refrain from telling the patient she has cancer.
B	You discuss her condition with her and inform her of the diagnosis of cancer. You stay with the patient to offer comfort and support.
C	You discuss the situation with the family and encourage them to tell her of the diagnosis of cancer. You place a call to the doctor to get permission to inform the patient, and offer to deliver the diagnosis if the family consents.

2) A 40 year old male patient who is an immigrant is being prepared to have surgery to treat lung cancer. The patient does not speak English but has signed the consent form. There is no family present. The patient nods yes to all questions but does not appear to understand what he is being asked. The nurse calls the surgery suite and the doctor to inform them that the consent is not valid. The doctor is infuriated and demands the patient be sent to surgery.

A	You refuse to send the patient to surgery and call for an interpreter.
B	You call the doctor, inform him of invalid consent, and page the nursing supervisor to deal with the situation.
C	You attempt to communicate with the patient, to inform to him that he is having lung surgery, and send him to surgery because the nurse knows it is in his best interests.

3) You are the nurse who is the buyer for the surgery department and you negotiate the price of a Laser Surgical System, placing the order on the hospital's behalf. The hospital has a policy against employees accepting gifts from suppliers. Today a courier delivered a popular best selling novel to you from the salesperson.

A	You accept the gift and do not tell her superior.
B	You refuse the gift and send it back to the sender by the courier.
C	You discuss the matter with your superior and plan to return the book if your superior feels it is inappropriate.

4) A 23 year old male comes into the clinic for a pre-employment physical examination. Included in the examination is a urine drug screen and HIV test for AIDS. The patient is not aware he is being tested for AIDS. His test comes back positive. Protocol is to send the results to the employer.

A	You notify the nurse practitioner or doctor at the clinic, send the results to the employer, and document the results in the chart.
B	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he then turns and walks out of the clinic.
C	You place a call to the patient to come by the clinic for his lab results. When the patient arrives, he states he was not hired by the company because he did not pass his physical examination, he turns to walk out but you redirect him to a vacant room and ask the nurse practitioner or doctor to discuss these findings with him.

5) A 95 year old female with a diagnosis of advanced dementia is a patient at an extended care facility in which you work. Several years ago, when she was more coherent, she stated repeatedly that she never wished to be kept alive by use of a feeding tube. Now she is unable to make decisions and has her niece as her surrogate decision maker. The niece consents to the insertion of a feeding tube placement and the patient is prepared to be sent for the procedure that afternoon.

A	You prepare the patient for the procedure because you understand that a feeding tube will provide for nutrition, fluids, and medications. This action is in the patient's best interest.
B	You attempt to contact the niece to relay information about the patient's wishes not to be kept alive by use of the feeding tube.
C	You notify the niece, the nursing supervisor, and the patient's doctor to relay the information that the patient did not wish to be kept alive by use of a feeding tube.

6) A nurse who is pursuing a Master's degree in nursing has decided to buy a new computer to assist in these studies. This nurse was able to purchase a state-of-the-art computer at a very affordable price but the trade off for getting a low price was that it came with a very limited amount of pre-loaded software. The nurse works at a local University Hospital and has access to the computer system. You are a co-worker of this nurse and many of other co-workers have mixed opinions about using unlicensed software but this nurse has decided to install software, licensed exclusively to her workplace, onto this new computer for personal use.

A	You should discuss the matter with their superior.
B	You should say nothing; if caught, the nurse will have to deal with the consequences.
C	You should report the nurse to the software company.

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7) An 18 month old female is in the Pediatric Intensive Care Unit (PICU) under your care. She has suffered burns from a car accident. There is an emergency in the Emergency Room (ER) which requires your expertise and takes you away from your present duties. You are asked to go to the ER to assist. The child in PICU becomes extremely agitated when you leave her.

A	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.
B	You call for another nurse to comfort the child in PICU and attend to the patient in the ER. The child in PICU is not consoled by the other nurse and then you call for someone else to assist in the ER and return to PICU.
C	You attempt to comfort the child in PICU first and then go to attend to the patient in the ER. The child in PICU is not consoled by the other nurse and must be sedated with medication.

8) A middle aged man is in front of you at the grocery store and falls to the floor. You realize in your assessment that he has stopped breathing and does not have a pulse. You initiate Cardiopulmonary Resuscitation (CPR). An ambulance arrives and a paramedic tells you he will take over. You realize the paramedic is incompetent and not performing CPR correctly.

A	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You resume CPR on the patient and tell the paramedic to call for backup assistance.
B	You inform the paramedic you are a nurse and that he is not performing CPR correctly. You instruct him in the proper technique and stay until backup assistance arrives.
C	You inform the paramedic you are a nurse and assist in 2-man CPR.

9) A nurse works at a community clinic where this year's flu vaccine is in short supply nationally and almost impossible to find locally. The clinic recently received a shipment of 50 vaccine doses, all of which are promised to people who previously stopped by the clinic to get their flu vaccine and were placed on a waiting list. The manufacturer of the vaccine assured the clinic manager that the clinic would receive another shipment soon. Another nurse in the clinic decided to call their spouse to come in for the flu vaccine before calling those on the waiting list. You work in the same clinic with this nurse.

A	You should say nothing.
B	You should talk to the nurse about this matter.
C	You should talk to your supervisor about this matter.

10) A 19 year old male is being admitted to the emergency room in extreme abdominal pain. When you palpate the RLQ, the patient hits you causing you to be slammed against the wall and fall to the floor. When you recover, you ask for another nurse to be assigned to his care. The other nurse who is assigned to care for him has gone to lunch and the patient is crying out in extreme pain, there are no other nurses available to assist in his care.

A	You attend the patient, evaluate his pain, and notify the nurse practitioner or doctor.
B	You attend to the patient and evaluate his pain. You document your observations and continue to monitor the patient.
C	You attend to the patient, evaluate his pain, and notify the nurse practitioner or doctor. You then call to get the test results, convey these results to the nurse practitioner or doctor.

11) A 25 year old female is being seen at your clinic for treatment of schizophrenia and is presently is becoming agitated because of paranoid delusions and having auditory hallucinations. She also has a diagnosis of mental retardation and has developed to a mental age of about 4 years. The nurse prepares to give her an injection of antipsychotic medication when the patient becomes hysterical. The nurse is not able to give the injection and notifies the ordering practitioner. The practitioner tells you to give the injection to her no matter what it takes.

A	You attempt to talk to the patient at a level she will understand and persuades her to calm down. You then attempt to administer the shot with assistance of other office personnel but she becomes hysterical again. You then goes back to the ordering practitioner.
B	You obtain assistance from other office personnel, enter the room, and talk to the patient. When she has calmed down, you tell her you are going to give her the injection, and administer the injection even though she starts to become hysterical when she sees the shot needle.
C	You obtain assistance from other office personnel and administers the injection. This medication is given in the patient's best interest and you know she would not understand even if you tried to explain it to her.

12) The nurse manager of a unit which cares for cancer patients receiving chemotherapy and radioactive treatments. Some of the patients have indwelling catheters which contain urine that is radioactive. The unit is short staffed and has pulled an aide from another unit to assist in taking vital signs and emptying the catheter bags. The aide is 10 weeks pregnant.

A	You offer to empty the bags for the aide knowing that performing these tasks will make you have to stay after your shift to finish your work.
B	You inform the aide of the radioactive urine and advise her to avoid emptying these bags.
C	You say nothing, knowing that the exposure to radioactivity is low and, since it will only be this one shift, should not cause any harm to the aide or her developing fetus.

13) At the health department in which you are employed, a 16 year old mother brings her child to be seen because she is complaining of abdominal pain. Upon examining the 4 year old female child, you observe that she is very quiet and allows you to examine her without hesitation. You note that the hymen is not intact, there is swelling in the vaginal area, and you suspect sexual abuse. You convey your findings to the mother who seems annoyed by your accusation. (The 16 year old mother is the daughter of the doctor who staffs the clinic)

A	You document these findings, notify the head nurse of the clinic, and summon the police to file a report.
B	You document these findings, notify the doctor which is the child's grandfather, and ask for further orders.
C	You document these findings, notify the doctor which is the child's grandfather, and inform him that these findings will be reported and a police report will be filed. You allow the doctor to speak with the mother and child.

14) You are shopping when you overhear two very young girls talking. One girl tells the other girl (who is pregnant) that drinking alcohol, taking aspirin, and consuming anti-freeze will cause her to have an abortion. You know the mother of the pregnant teenage girl.

A	You call the mother of the pregnant teenage girl to inform her of what you heard because you know it is in the girl's best interest.
B	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You do not tell the girl's mother because this would be a breach of confidentiality.
C	You stop and talk to the pregnant teenage girl. You tell her that you are a nurse and that this could endanger her life if she pursues ingesting these substances. You then call the girl's mother to inform her of what you heard in order to protect her.

15) You are the surgical nurse circulating at a surgery for a patient undergoing the removal of an ovarian cyst; the patient has a diagnosis of AIDS. The surgeon performs the cyst removal and begins to perform a tubal ligation (for which there is no consent to perform). You inform the surgeon that the consent does not state that a tubal ligation will be performed. The surgeon comments that patient has AIDS and indicated to the surgeon that she wanted a tubal ligation and the surgeon must have forgotten to put it on the consent form.

A	You tell the surgeon to stop the tubal ligation and notify the nurse manager of surgery of the situation.
B	You allow the operation to proceed and notify the nurse manager of surgery of the situation.
C	You tell the surgeon to stop the tubal ligation, notify the nurse manager of surgery of the situation, and tell the patient about the situation after she wakes from anesthesia.

APPENDIX I
Introductory Letter

To Fellow RN,

My name is Lisa Byrd, I am an RN, and a doctoral student at The University of Southern Mississippi. I need your help. I am asking your assistance in gathering some very important information. This survey is being conducted to understand the current practices of nurses in ethically-sensitive situations. I realize your time is valuable and this survey will take approximately 30 minutes. Complete the survey, return it in the enclosed envelop, and also complete the postcard to be entered in a drawing for a **\$100.00 Wal-Mart gift certificate**. The postcards and the survey will be separated when received and no correlation will be made between the survey and you. The researcher will keep all data and questionnaires for 5 years in a locked file cabinet and then destroy it.

Your assistance is greatly needed. Ethics in nursing practice is coming under much criticism and scrutiny, and ways to understand nursing practice is necessary to support the fact that nursing is a profession that contributes significantly to the well-being of our patients. Please help me in this quest of understanding the ethical thinking involved in your nursing practice today.

The survey will be answered anonymously and the results will be reported as a summary of the findings. Your return of the completed survey will imply your permission to participate in the study. This project has been reviewed by the Human Subjects Protection Review Committee, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research subject should be directed to the chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-6820.

If you would like to receive the results of the survey, check the box on the postcard that you return to be entered in the drawing for a \$100.00 Wal-Mart gift certificate. Please return the survey and postcard by February 28, 2006.

Thank you for all of your help!

Sincerely,

Lisa Byrd RN

APPENDIX J

Demographic Data

1. Your Educational Degree in Nursing:
____(a) Diploma ____ (b) Associate Degree ____ (b) Bachelor Degree
____(c) Master's Degree ____ (d) Doctoral or PhD
2. Have you attained any specialty certifications: ____ No ____ Yes
If so, Please Specify _____
3. Total Years in Nursing Practice as an RN: _____
4. Type of Work Setting: ____ Hospital ____ Community/Outpatient ____ Education
Other, please specify _____
5. Specialty in Nursing, please specify _____
6. Years of practice in current specialty of nursing: _____
7. How much continuing education do you obtain annually:
____(a) None ____ (b) 1-10 hours ____ (c) 11-20 hours ____ (d) greater than 20
hours
8. Is continuing education mandatory for your license recertification or for work?
____ Yes ____ No
9. Age: ____ 18-25 ____ 26-35 ____ 36-45 ____ 46-55 ____ 56-65 ____ 65 and older
10. Race: ____ (a) Caucasian ____ (b) African-American ____ (c) Hispanic ____
(d) Other, Please specify _____
11. Sex: ____ Female ____ Male
12. I am inquiring about ethics education in your program for nursing education:
____ Ethics education was integrated in my nursing program that significantly
affected my education
____ Ethics education was integrated in my nursing program but was not
emphasized
____ Ethics education was a separate course taught in my nursing program
____ Ethics education was not included in my nursing program

APPENDIX K

Virtues as defined by Benner (2001)

Virtue	Definition
Compassion	an empathetic understanding of challenges in health, sympathetic response, and a disposition to alleviate suffering or to comfort
Fidelity to trust	Honesty and promotion of patient well-being such that a patient can trust the nurse's benevolence
Moral Courage	Willingness to risk personally to protect the safety of a patient and promote patient well-being
Justice	Giving what is due to each person including respect and promotion of well-being; commitment to fair distribution of health care resources and costs to the community
Mediation	Disposition to facilitate cooperation and communication among nurses, patients, families, and other health care providers
Self-confidence	Respect for one's own professional abilities and knowledge
Resilience	Ability to recover from loss or stress; ability to see oneself not as a victim but as an advocate for one's patient, one's profession, and oneself
Practical reasoning	Ability to identify relevant moral considerations and to actively interpret particular situations and adapt
Integrity	Ability to integrate one's personal and professional life in such a way that the nurse is morally whole, consistent, and trustworthy

APPENDIX L

Scoring of the Byrd's NEST and MES scenarios i.e. Byrd's NEST P-3

Each answer or choice of action is scored on a scale of low, medium, or high degree of ethical sensitivity for the Byrd's NEST questions, as well as the 5 questions adapted from the Multidimensional Ethics Survey (Reidenbach & Robin, 1990).

Degree of ethical sensitivity: High Medium Low

#1:Byrd's NEST Question 1	C	B	A
#2:Byrd's NEST Question 2	A	B	C
#3:MES Question 1	A	B	C
#4:Byrd's NEST Question 3	C	A	B
#5:Byrd's NEST Question 4	B	C	A
#6:MES Question 2	A	C	B
#7:Byrd's NEST Question 5	B	A	C
#8:Byrd's NEST Question 6	B	A	C
#9:MES Question 3	B	C	A
#10:Byrd's NEST Question 7	C	A	B
#11:Byrd's NEST Question 8	B	C	A
#12:MES Question 4	A	B	C
#13:Byrd's NEST Question 9	A	C	B
#14:Byrd's NEST Question 10	B	C	A
#15:MES Question 5	A	C	B

APPENDIX M

Virtues in Questions

Virtue	Question(s)
Compassion: An empathetic understanding of challenges in health, sympathetic response, and a disposition to alleviate suffering or to comfort	#1 #4 #5 Main virtue #7 #8
Fidelity to trust: Honesty and promotion of patient well-being such that a patient can trust the nurse's benevolence	#1 Main virtue #3 #4 #10
Moral Courage: Willingness to risk personally to protect the safety of a patient and promote patient well-being	#1 #4 #9 Main virtue
Justice: Giving what is due to each person including respect and promotion of well-being; commitment to fair distribution of health care resources and costs to the community	#3 Main virtue
Mediation: Disposition to facilitate cooperation and communication among nurses, patients, families, and other health care providers	#8 Main virtue
Self-confidence: Respect for one's own professional abilities and knowledge	#5 #6 Main virtue
Resilience: Ability to recover from loss or stress; ability to see oneself not as a victim but as an advocate for one's patient, one's profession, and oneself	#7 Main virtue
Practical reasoning: Ability to identify relevant moral considerations and to actively interpret particular situations and adapt	#5 #6 Main virtue
Integrity: Ability to integrate one's personal and professional life in such a way that the nurse is morally whole, consistent, and trustworthy	#2 Main virtue #10

APPENDIX N

Permission for use of Moral Sensitivity Questionnaire (MSQ) from Lutzen: email communications

Yes you may use portions of the MSQ. I would be interested in hearing about your results and publications using this instrument

Kind regards

[Lützen Kim] Kim Lützn -----Ursprungligt meddelande-----

Från: Lisa Byrd [mailto:lbyrd@jam.rr.com]

Skickat: den 7 juni 2005 19:31

Till: Lützen Kim

Ämne: Re: Request for information on MSQ

Kim,

I would like your permission to use portions of your instrument the moral sensitivity questionnaire (MSQ) in my instrument to assess ethics of nurses while pursuing my dissertation at The University of Southern Mississippi.

Please email a response,

thank you for this consideration,

Lisa Byrd

lbyrd@jam.rr.com

From: Lützen Kim

To: Lisa Byrd

Sent: Friday, March 11, 2005 11:21 AM

Subject: SV: Request for information on MSQ

I am the sole author of the questionnaire. I will send you more info. in a few days

kind regards

Kim Lützn

Från: Lisa Byrd [mailto:lbyrd@jam.rr.com]

Skickat: den 11 mars 2005 14:52

Till: Lützen Kim

Ämne: Request for information on MSQ

Kim Lutzen,

My name is Lisa Byrd, I am a PhD nursing student at the University of Southern Mississippi.

I am seeking a more detailed description and reliability/validity information about the Moral Sensitivity Questionnaire (MSQ).

If this is permissible, I need more details about the instrument and each specific question.

And who has copywriter privileges to ask permission to use parts of the questionnaire.

Is there more information that I can get or a dissertation to acquire?

I think you guys did a great job on this instrument and appreciate your efforts in this subject matter.

Please respond if you are not this author so I can continue my search,

Thanks again

APPENDIX O

Permission for use of Multidimensional Ethics Scale (MES) from Reidenbach: email communication

You have my complete permission to do so. Good luck

Eric Reidenbach
127 Fair Lake Drive
Hattiesburg, MS 39402
601 2687479
eric@marketvaluesolutions.com

From: Lisa Byrd [mailto:lbyrd@jam.rr.com]
Sent: Tuesday, June 07, 2005 9:12 AM
To: Eric
Subject: permission to use an adaptation of your MES

Eric Reidenbach,

Thanks for answering my email.
I am working on my dissertation in Nursing Ethics at the University of Southern Mississippi.
I am creating a new instrument. I would like to adapt some of the scenarios from your
Multidimensional Ethics Scale to use as a source of concurrent validity in development of my
instrument.
I am requesting permission to do this.

Please let me know if this is permissible.

Thank you again,

Lisa Byrd
lbyrd@jam.rr.com

----- Original Message -----

From: Eric
To: lbyrd@jam.rr.com
Sent: Tuesday, June 07, 2005 9:30 AM
Subject: Lisa:

Lisa: I got your message through the MWCMC. What can I do? I have left academia about 10 years ago so I'm not sure I will be of any help. You might contact Don Robin at Wake Forest. I think he is still active in the area. Nonetheless if I can be of help, give me a call or email.

Eric Reidenbach
127 Fair Lake Drive
Hattiesburg, MS 39402
601 2687479
eric@marketvaluesolutions.com

APPENDIX P



The University of
Southern Mississippi

Institutional Review Board

118 College Drive #5147
Hattiesburg, MS 39406-0001
Tel: 601.266.6820
Fax: 601.266.5509
www.usm.edu/irb

HUMAN SUBJECTS PROTECTION REVIEW COMMITTEE NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Human Subjects Protection Review Committee in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 25103105

PROJECT TITLE: **Development of an Instrument to Identify the Virtues of Expert Nursing: "Byrd's Nurses' Ethical Sensitivity Test" (Byrd's Nest)**

PROPOSED PROJECT DATES: 11/30/05 to 12/31/06

PROJECT TYPE: **Dissertation or Thesis**

PRINCIPAL INVESTIGATORS: **Lisa M. Byrd**

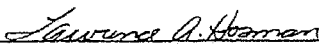
COLLEGE/DIVISION: **College of Health**

DEPARTMENT: **School of Nursing**

FUNDING AGENCY: **N/A**

HSPRC COMMITTEE ACTION: **Exempt Approval**

PERIOD OF APPROVAL: 11/17/05 to 11/16/06


Lawrence A. Hosman, Ph.D.
HSPRC Chair

11-18-05
Date

APPENDIX Q

Scoring of the Byrd's NEST (final version)

Each response or choice of action is scored on a scale of low, medium, or high degree of ethical sensitivity.

Degree of ethical sensitivity: High Medium Low

#1: 52 y/o* female with diagnosis of cancer	C	B	A
#2: 40 y/o male immigrant-language barrier	A	B	C
#3: 23 y/o male-pre-employment physical for AIDS test	C	A	B
#4: 95 y/o female with advanced dementia	B	C	A
#5: 10 month old female not comforted in PICU	B	A	C
#6: middle aged man needing CPR	B	A	C
#7: 19 y/o male in Emergency Room with abdominal pain	C	A	B
#8: 25 y/o female with schizophrenia needing shot	B	C	A
#9: child with abdominal pain at health department	A	C	B
#10: young girl seeking abortion	B	C	A

*y/o = years old

REFERENCES

- American Association of Colleges of Nursing. (2004). Your nursing career: A look at the facts. Education Center. Retrieved March 8, 2006, online from <http://www.aacn.nche.edu/education/Career.htm>
- American Nurses Association's Code of Ethics (2001). Washington D.C.: ANA.
- Aristotle. (trans. 2002). *Nichomachean ethics*. (C. Rowe, Translated; S. Broadie, Intro. & Commentary). New York: Oxford University Press.
- Armstrong, A., Parsons, S., & Barker, P. (2000). An inquiry into moral virtues, especially compassion in psychiatric nurses: findings from a delphi study. *Journal of Psychiatric and Mental Health Nursing*, 7, 292-306.
- Ashley, B, & O'Rourke, B. (2002). *Ethics of health care* (3rd ed.). Washington D.C.: Georgetown University Press.
- Baly, M. (1986). *Florence Nightingale and the nursing legacy*. London: Croom Helm.
- Baron, M. (1999). *Kantian ethics almost without apology*. Ithaca, NY: Cornell University Press.
- Becker, L., & Becker, C. (1992). *A history of western ethics*. New York: Garland Publishing.
- Benner, P. (2000). *From silence to voice. What nurses know and must communicate to the public*. [Foreword]. Ithaca, NY: Cornell University Press.
- Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice*. Upper Saddle River, NJ: Prentice Hall.

Benner, P., Hooper-Kyriakidis, P., & Stannard, D. (1999). *Clinical wisdom and interventions in critical care: A thinking-in-action approach*.

Philadelphia, PA: Saunders.

Benner, P., Tanner, C., & Chesla, C. (1996). *Expertise in nursing practice: caring, clinical judgment, and ethics*. New York: Springer Publishing.

Butts, J. (2003). Lecture notes: Nursing Ethics. Hattiesburg, MS: The University of Southern Mississippi, School of Nursing.

Butts, J., & Rich, K. (2005). Preface. *Nursing ethics: Across the curriculum and into practice*. Boston, MA: Jones & Bartlett.

Chambliss, D. (1996). *Beyond caring: Hospitals, nurses, and the social organization of ethics*. Chicago: University of Chicago Press.

Corrigan-Wandell, J. (2003) Charting the course: The power of expert nurses to define the future. Paper presented at the meeting of the Institute of Nursing Healthcare Leadership (September 21-23, 2003). Boston, MA.

Medscape Nurses, what course of action they would pursue in the dilemma. Each response or choice of action was scored on a scale of low, medium, or high degree 5.

Cua, A. (1978). *Dimensions of moral creativity*. University Park, PA: Pennsylvania State University Press.

Denise, T., White, N., & Peterfreund, S. (2002). *Great traditions in ethics* (10th ed.). Belmont, CA: Wadsworth Group/Thompson Learning.

Doane, G. (2002). Am I still ethical? The socially-mediated process of nurses' moral identity. *Nursing Ethics*, 9, 627-639.

- Dodd, S., Jansson, B., Brown-Saltzman, K., Shirk, M., & Wunch, K. (2004). Expanding nurses' participation in ethics: An empirical examination of ethical activism and ethical assertiveness. *Nursing Ethics*, 11, 15-27.
- Gastmans, C. (2002). A fundamental ethical approach to nursing: some proposals for ethics education. *Nursing Ethics*, 9, 494-507.
- Gordon, S., Benner, P., & Noddings, N. (1996). *Caregiving: Readings in knowledge, practice, ethics, and politics*. Philadelphia, PA: University of Pennsylvania Press.
- Graziano, A., & Raulin, M. (2000). *Research methods: A process of inquiry*. (4th ed) Boston: Allyn and Bacon. 88-89.
- Habel, M. (2005). Bioethics: strengthening nursing's role. *Nurse Week Online Journal*. Retrieved February 8, 2005, from <http://www.nurseweek.com/ce/ce420a.html>
- Hampton, J. (1988). *Hobbes and the social contract tradition*. Cambridge, United Kingdom: Cambridge University Press.
- Howell, D. (2002). *Statistical methods for psychology* (5th ed.). Duxbury, VT: Wadsworth Group.
- Hyman, M. (1996). A critique and revision of the multidimensional ethics scale. *Journal of Empirical Generalizations in Marketing Science*, 1, 1-35.
- Johnstone, M. (2005). *Bioethics: A nursing perspective* (4th ed.). St. Louis, MO: Churchill Livingstone.
- Jhingran, S. (1989). *Aspects of hindu morality*. Delhi: Barnaasidass Publishers.
- Karseth, B. (2004). Curriculum changes and moral issues in nursing education. *Nursing Education Today*, 24(8), 638-643.

- Kelly, B. (1993). The 'real world' of hospital nursing practice as perceived by nursing undergraduates. *Journal of Professional Nursing*, 9, 27-33.
- Kelly, C. (2000). *Nurses' moral practice: Investing and discounting self*. Indianapolis, IN: Sigma Theta Tau International.
- Keyser, P. (1989). Dissertation: From angels to advocates: The concept of virtue in nursing ethics from 1870 to 1980. Dallas: University of Texas.
- Kim, M. (1999). A study on the ethical value of clinical nurses. Unpublished doctoral dissertation, Hanyang University, Korea.
- Kim, Y., Park, J., You, M., Seo, Y., & Han, S. (2006). Sensitivity to ethical issues confronted by Korean hospital staff nurses. *Nursing Ethics*, 12, 595-605.
- Lutzen, K., Everton, M., & Nordin, C. (1997). Moral sensitivity in psychiatric practice. *Nursing Ethics*, 4, 472-482.
- Lutzen, K., Johansson, A., & Nordstrom, G. (2000). Moral sensitivity: some differences between nurses and physicians. *Nursing Ethics*, 7, 520-530.
- Machiavelli, J. (1970). *Character*. New York: Oxford University Press.
- MacDonald, S., & Stump, E. (1999). *Aquinas's moral theory*. Ithaca, NY: Cornell University Press.
- MacIntyre, A. (1984). *After virtue*. (2nd ed.). Notre Dame, IN: University of Notre Dame Press.
- MacIntyre, A. (1988). *Whose justice? Which rationality?* Notre Dame, IN: University Of Notre Dame Press.
- MacIntyre, A. (1990). *Three rival versions of moral enquiry*. Notre Dame, IN: University of Notre Dame Press.

- MacIntyre, A. (1998). *A short history of ethics: A history of moral philosophy from the homeric age to the twentieth century* (2nd ed.). Notre Dame, IN: Indiana: University of Notre Dame Press.
- Mangus, B., & Higgins, K. (1996). *The Cambridge companion to Nietzsche*. Cambridge, MA: Harvard University Press.
- McAlpine, H., Kristjanson, L., & Porocho, D. (1997). Development and testing of the ethical reasoning tool (ERT): An instrument to measure ethical reasoning of nurses. *Journal of Advanced Nursing*, 25, 1151-1161.
- McMurty, J. (1978). *The structure of Marx's world-view*. Princeton, NJ: Princeton University Press.
- Murdoch, I. (1992). *Metaphysics as a guide to morals*. New York: Penguin Press.
- Nietzsche, F. (trans. 1967). *On the genealogy of morals and ecce homo*. (translated by Kaufmann). New York: Vintage Books.
- National Advisory Council on Nursing Education and Practice. (2002). Second report to the Secretary of Health and Human Services and the Congress. Retrieved March 8, 2006, from <http://bhpr.hrsa.gov/nursing/nacnep.htm>
- National League of Nursing Accrediting Commission [NLNAC]. (2003). Interpretive guidelines by program type: Core competencies for practicing nurses—adapted by NLNAC. Retrieved August 18, 2004, online from <http://www.nlnac.org/>
- Nunnally, J., & Bernstein, I. (1994). *Psychometric theory* (3rd ed.). McGraw-Hill: New York.
- Nursing*. (2004). Magnet hospitals: nursing excellence added to survey criteria, 34, 34.

- Oakley, J., & Cocking, D. (2001). *Virtue ethics and professional roles*. New York: Cambridge University Press.
- Pang, S., Sawada, A., Konishi, E., Olsen, D., Yu, P., Chan, M., & Mayumi, N. (2003). A comparative study of Chinese, American, and Japanese nurses' perceptions of ethical role responsibilities. *Nursing Ethics*, 10, 295-311.
- Park, S. (2002). Ethical values of doctors and nurses in hospital medical practice. Unpublished master's thesis, Kyungpook National University, Korea.
- Pellegrino, E. (June 2003). Intensive Bioethics Course XXIX. Symposium conducted on Bioethics at Kennedy Institute of Ethics. Washington D.C.: Georgetown University.
- Pellegrino, E. (1995). Toward a virtue-based normative ethic for the health professions. *Kennedy Institute of Ethics Journal*, 5, 253-277.
- Pellegrino, E., Veatch, R., & Langan, J. (1991). *Ethics, Trust, and the professions: Philosophical and cultural aspects*. Washington D.C.: Georgetown University Press.
- Peterson, C., & Seligman, M. (2004). *Character strengths and virtues: A handbook and classification*. New York: Oxford University Press.
- Peterson, E. (1994). Teach us to care and not to care. *The crisis of care: Affirming and restoring caring practices in the helping professions*. Washington D.C.: Georgetown University Press.
- Phillips, S., & Benner, P. (1994). *The crisis of care: Affirming and restoring caring practices in the helping professions*. Washington D.C.: Georgetown University Press.

- Pilot, D., & Hungler, B. (1995). *Nursing research: Principles and methods*. (5th ed). Philadelphia: Lippencott Company.
- Rand, A. (1964). *The virtue of selfishness*. New York: Signet Books.
- Reck, L. (1983). *Studies in the philosophy of David Hume*. New York: Garland.
- Redman, B. (2002). *Measurement instruments in clinical ethics*. California: Sage Publications.
- Reidenbach, R. E., & Robin, D. (1990). Toward the development of a multidimensional scale for improving evaluations of business ethics. *Journal of Business Ethics*, 9, 639-653.
- Rhodes, R. (2002). Two concepts of medical ethics and their implications for medical ethics education. *Journal of Medicine and Philosophy*, 27, 493-508.
- Slote, M. (1997). From morality to virtue. In D. Statman (Ed.), *Virtue ethics: A critical reader*. Washington D.C.: Georgetown University Press.
- Smith, K., & Godfrey, N. (2002). Being a good nurse and doing the right thing: a qualitative study. *Nursing Ethics*, 9, 301-311.
- Smith, S. (2005). Ethical enculturation: a nursing concept for the education of baccalaureate nursing students. Retrieved February 8, 2005, from <http://fp.hsu.edu/faculty/afo/2001-02/smith.htm>
- Statman, D. (1997). Introduction to virtue ethics. In D. Statman (Ed.), *Virtue ethics: A critical reader*. Washington D.C.: Georgetown University Press.
- Tchudin, V. (2003). *Approaches to ethics: Nursing beyond boundaries*. Philadelphia, PA: Elsevier Science Limited.

- Thomasma, D. (1997). *The influence of Edmund D. Pellegrino's philosophy of medicine*. Maywood, Ill: Kluwer Academic Publishers.
- Thomson, J. (1962). *The ethics of Aristotle*. London, UK: Penguin Books.
- Urbina, S. (2004). *Essentials of psychological testing*. Hoboken, NJ: John Wiley & Sons.
- Volbrecht, R. (2002). *Nursing ethics: Communities in dialogue*. Upper Saddle River, NJ: Pearson Education.
- Varcoe, C., Doane, G., Pauly, B., Rodney, P., Storch, J., Mahoney, K.
McPherson, G., Brown, H., & Starzomski, R. (2004). Ethical practice in nursing: Working the in between. *Journal of Advanced Nursing*, 45, 316-325.
- World Book Encyclopedia*. (1998). Chicago, Ill: World Book.
- Yearly, L. (1990). *Mencius and Aquinas*. Albany, NY: State University of New York Press.